

# The Good Health Handbook:

## A Guide for Those Caring for Children



Oklahoma State  
Department of Health  
Creating a State of Health





# GOOD HEALTH HANDBOOK

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## Introduction

If you work with young children you understand the importance of keeping every child healthy and safe. This handbook will help you by providing up-to-date information on health, safety, and development issues. The Good Health Handbook is **a good resource for all types of child care programs and schools** working with and caring for young children.

The Good Health Handbook has been revised and updated and it includes much of the information you will need about injury prevention, infection control, childhood conditions, illnesses, infestations, and injuries. It contains information on the importance of developing policies for your program, as well as sample policies. There is also helpful information on the importance of good nutrition, physical activity, outdoor time, child development, guiding children's behavior, and working with families. Many of the additions and revisions are based on the suggestions and requests from those who use the Good Health Handbook.

The information in this handbook has been carefully researched and reviewed. Recommendations are made only if there is good evidence that it will help protect the health and safety of the children in your care and their families. However, **this book is only a guideline to follow and is in no way intended to replace the recommendations of health care providers.**

The 2015 revised edition of the *Good Health Handbook: A Guide for Those Caring for Children* was developed by a dedicated group of early childhood and health professionals with funding and support provided by the Department of Human Services Child Care Services, and the Oklahoma State Department of Health Maternal and Child Health Service.

Special thanks to the Good Health Handbook Revisions Committee for their creative ideas and their many hours of research, meetings, and work!

## Common Health Myths

There are some “*common health myths*” that many of us have heard growing up and we continue to hear from family members, friends, and even early childhood and health professionals. To help you provide high quality care for children here are some straight answers to many of those myths.

**Myth:** Cold weather makes you sick.

**The truth is:** You may feel uncomfortable, but cold air doesn’t make you sick. *Germs make you sick*. Studies have shown that people who are chilled are no more likely to get sick than those who are not. It may be that cold weather keeps people indoors, where germs are more likely to catch up with you. **TAKE THE CHILDREN OUTSIDE for fresh air!**

**Myth:** If you go outside with wet hair, you’ll catch a cold.

**The truth is:** You may feel cold or uncomfortable, but will be just fine health-wise.

**Myth:** Putting cotton balls in your ears protects you from an infection.

**The truth is:** The cotton actually helps trap moisture and provides a better growth medium for a bacterial infection.

**Myth:** You lose most of your body heat through your head.

**The truth is:** There is nothing special about the head and heat loss. Heat escapes from any exposed area, so putting on gloves or mittens is as important as a hat.

**Myth:** Green mucus (snot) means a child has something worse than a cold.

**The truth is:** The importance of mucus color is a medical myth that even some doctors believe. Clear mucus is most common, but green or yellow could be temporary, or a symptom of a cold.

**Myth:** Herbal remedies such as echinacea and licorice root are safe and helpful to a sick child.

**The truth is:** Few herbal remedies have undergone rigorous testing and could in fact harm a child.

**Myth:** All ear infections need to be treated with antibiotics.

**The truth is:** About 80 percent of ear infections will clear up on their own, and overuse of antibiotics has led to bacteria developing resistance to the drugs. Therefore many doctors are taking a “wait and see” approach.

**Myth:** Feed a cold, starve a fever.

**The truth is:** All sick children, whether feverish or sniffing, need nutrients. If they don’t feel like eating solid food, make sure they get plenty of soup, juice, and other healthy soft foods and liquids. Staying hydrated is the most important thing.

**Myth:** A flu shot will make you sick.

**The truth is:** A flu shot **cannot** cause illness. Flu vaccine administered by a needle is made in two ways. The vaccine is made with flu vaccine viruses that have been ‘inactivated’ and are not infectious, or with no flu vaccine viruses at all.

**Myth:** Vaccines cause autism.

**The truth is:** Vaccines do not cause autism. Science fails to show a link between vaccines and autism. In recent years, there has been a shift in the definition of autism, which makes it seem like rates have increased. Autism is now recognized as a 'spectrum disorder' with many more mild cases that were previously never classified as "autism."

**Myth:** Vaccines are not necessary because we have good hygiene and sanitation.

**The truth is:** The diseases we can vaccinate against will return if we stop vaccination programs. Better hygiene, hand washing and clean water help protect people from infectious diseases, but many infections can spread regardless of how clean we are. If people are not vaccinated, diseases that have become uncommon in the U.S., such as polio and measles, will quickly reappear.

**Myth:** Too many shots weaken the immune system.

**The truth is:** Each dose allows the body to mount an immune response and make antibodies to fight off an infection if one showed up.

**Myth:** To get rid of hiccups, have someone startle you.

**The truth is:** Most home remedies, like holding your breath or drinking from a glass of water backward have not been proven effective. However swallowing one teaspoon of white granulated sugar has been proven effective 95% of the time.

**Myth:** Sugar makes children hyperactive.

**The truth is:** Sugar does not cause hyperactivity. There are many other health-related reasons not to consume a lot of sugar. (However it has been proven to get rid of hiccups – see above).

**Myth:** Cracking your knuckles will cause arthritis.

**The truth is:** Knuckle crackers are no more likely to have arthritis than those who don't make annoying popping sounds with their fingers, but there are reasons to stop this habit. Knuckle crackers are more likely to have weaker grip strength and greater hand swelling.

**Myth:** Gum stays in your stomach for seven years.

**The truth is:** Like most nonfood objects that children swallow, fluids carry gum through the intestinal tract, and within days it passes.

**Myth:** The 5-second rule – if food dropped on the floor is picked up quickly it is safe to eat.

**The truth is:** Scientists put the 5-second rule to the test. They found that food that comes into contact with tile, wood, and carpeted floors picks up large amounts of bacteria. Throw it out!

**Myth:** Sitting too close to the TV will damage a child's eyes.

**The truth is:** Sitting in front of the TV or a computer screen for hours may have a negative effect on your child's brain development, but it will not damage their eyes. If a child is sitting too close to the TV or the computer screen, it may be a sign the child needs to have an eye exam.

**Myth:** Eating lots of carrots will improve a child's eyesight.

**The truth is:** Carrots contain carotene (which becomes Vitamin A), a key ingredient in good overall nutrition, however eating a lot of them will not improve your eyesight.

**Myth:** Teething sometimes causes high fevers, diaper rash, diarrhea, or ear infections.

**The truth is:** Although teething causes discomfort and some studies have linked it to low-grade fever, teething does not cause a high fever, diaper rash, diarrhea, or ear infections.

**Myth:** Wounds need fresh air to heal.

**The truth is:** A covered wound will heal faster, with less scarring, than an uncovered one. An ordinary bandage holds in the moisture, which prevents the skin from drying out and scabbing over. Scabs slow down the healing process by creating a barrier between healthy cells and the damaged cells that need repair.

**Myth:** Pets spread head lice.

**The truth is:** Animals are not known to carry head lice or transmit them to people.

**Myth:** A lice infestation means you are 'dirty'.

**The truth is:** Personal cleanliness and family income have nothing to do with having or transmitting head lice. "The head louse is an equal-opportunity pest."

**Myth:** Kids with lice or nits should be sent home immediately.

**The truth is:** The American Academy of Pediatrics does not endorse a 'no-nit' policy that excludes children from school because nits are present.

**Myth:** Lice and bed bugs carry diseases.

**The truth is:** Head lice and bed bugs do not cause or spread diseases.

**Myth:** Bed bugs live in dirty places.

**The truth is:** Anyone can get bed bugs. Unsanitary conditions will not cause bed bugs, but getting rid of clutter will help reduce the number of places bed bugs can live and hide.

**Myth:** Bed bugs can't be seen with the naked eye.

**The truth is:** Bed bugs are small but can be seen. Young bed bugs are about the size of a poppy seed and mature ones are about the size of an apple seed.

**Myth:** If a baby spits up while sleeping on its back it will choke.

**The truth is:** Babies can keep their airways open better when on their backs. The wind pipe is above the food pipe when babies are on their backs, so it would be difficult for vomit or spit-up to travel against gravity.

**Myth:** Baby's bottle must be warmed.

**The truth is:** It's perfectly safe to serve a baby a cold bottle.

**Myth:** Infants need water supplements.

**The truth is:** Healthy babies **do not** need extra water. Breast milk and formula provide all the fluids they need. On hot days, infants receiving human milk in a bottle can be given additional human milk in a bottle but should not be given water, especially in the first six months of life. Infants receiving formula in a bottle can be given additional formula in a bottle.

Resources:

[www.parents.com](http://www.parents.com)

[www.chla.org](http://www.chla.org)

[www.rd.com/advice/child-health-myths-every-parent-should-know](http://www.rd.com/advice/child-health-myths-every-parent-should-know)

<http://liparentonline.com>

<http://spryliving.com/articles.kids-health-myths/>

[www.foxnews.com/health/2013/08/17/12myths-and-facts-about-vaccines/](http://www.foxnews.com/health/2013/08/17/12myths-and-facts-about-vaccines/)

<http://children.webmd.com>

<http://www.cdc.gov/flu/about/qa/misconceptions>

[www.epa.gov/bedbugs/](http://www.epa.gov/bedbugs/)

[www.babycenter.com](http://www.babycenter.com)

[www.healthtap.com](http://www.healthtap.com)

[www.nichd.nih.gov](http://www.nichd.nih.gov)

[www.healthychildren.org](http://www.healthychildren.org)



# Chapter 1: The Successful Caregiver





## **Chapter 1: The Successful Caregiver**

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## Code of Ethical Conduct

### Why have a code of ethical conduct?

As an early childhood professional a code of ethical conduct will benefit your work with families and your program. A code of conduct should be a guide and reference to look to in day-to-day decision-making.

A code provides visible guidelines for behavior and is a tool to encourage discussions of ethical dilemmas, prejudices, and gray areas that are encountered in everyday work – all beneficial when working with children and families.

### Definition of ethics from Dictionary.com:

- rules of conduct recognized in respect to a particular class of human actions or a particular group, culture, etc.
- moral principles, as of an individual
- that branch of philosophy dealing with values relating to human conduct, with respect to the rightness and wrongness of certain actions and to the goodness and badness of the motives and ends of such actions

A **code of ethics** is a set of principles and rules used by businesses, professional organizations, and individuals to govern their decision making in choosing between right and wrong. A code of ethics defines the core values of the field and provides guidance for what professionals should do when they encounter conflicting obligations or responsibilities in their work.

The National Association for the Education of Young Children (NAEYC) recognizes that those who work with young children face many decisions that have moral and ethical implications. The **NAEYC Code of Ethical Conduct** offers guidelines for responsible behavior and provides a common basis for resolving ethical dilemmas encountered in early care and education programs.

The primary focus of the Code is on daily practice with children and their families in programs for children from birth through 8 years of age, such as infant/toddler programs, preschool and prekindergarten programs, child care centers, hospital and child life settings, family child care homes, kindergartens, and primary classrooms. When the issues involve young children, then these provisions also apply to specialists who do not work directly with children, including program administrators, parent educators, early childhood adult educators, and officials with responsibility for program monitoring and licensing. (Note: See also the “Code of Ethical Conduct: Supplement for Early Childhood Adult Educators,” online at <http://www.naeyc.org/about/positions/pdf/ethics04.pdf>, and the “Code of Ethical Conduct: Supplement for Early Childhood Program Administrators,” online at [http://www.naeyc.org/files/naeyc/file/positions/PSETH05\\_supp.pdf](http://www.naeyc.org/files/naeyc/file/positions/PSETH05_supp.pdf))

### The code provides a framework of professional responsibilities in four sections:

- Ethical responsibilities to children
- Ethical responsibilities to families
- Ethical responsibilities to colleagues
- Ethical responsibilities to community and society

### **NAEYC Statement of Commitment**

The Statement of Commitment is not part of the Code but is a personal acknowledgement of an individual's willingness to embrace the values and moral obligations of the field of early childhood care and education.

**As an individual who works with young children, I commit myself to furthering the values of early childhood education as they are reflected in the ideals and principles of the NAEYC Code of Ethical Conduct. To the best of my ability I \_\_\_\_\_ will:**

- Never harm children.*
- Ensure that programs for young children are based on current knowledge and research of child development and early childhood education.*
- Respect and support families in their task of nurturing children.*
- Respect colleagues in early childhood care and education and support them in maintaining the NAEYC Code of Ethical Conduct.*
- Serve as an advocate for children, their families, and their teachers in community and society.*
- Stay informed of and maintain high standards of professional conduct.*
- Engage in an ongoing process of self-reflection, realizing that personal characteristics, biases, and beliefs have an impact on children and families.*
- Be open to new ideas and be willing to learn from the suggestions of others.*
- Continue to learn, grow, and contribute as a professional.*
- Honor the ideals and principles of the NAEYC Code of Ethical Conduct.*

## **Cultural Considerations and Valuing Diversity**

**Valuing diversity** means that we are comfortable with who we are as individuals and are able to accept and appreciate the differences of ourselves and of others. Diversity encompasses all of the differences we possess as humans.

Young children and their families reflect a rapidly increasing diversity of language and culture. The National Association for the Education of Young Children (NAEYC) recommends that early childhood programs create a welcoming environment that respects diversity, supports children's ties to their families and community, and promotes second language acquisition and preservation of children's home languages and cultural identity.

### **Recommendations for working with families:**

- Actively involve families in the early learning program.
- Help all families realize the cognitive advantage of a child knowing more than one language, and provide them with support to maintain and preserve their home language.
- Show families that their home's cultural values and norms are honored.

### **Recommendations for working with young children:**

- Ensure that children remain cognitively, linguistically, and emotionally connected to their home language and culture.
- Encourage home language and literacy development, knowing that this contributes to children's ability to acquire English language proficiency.
- Help develop essential concepts in the children's first language and within cultural contexts that they understand.
- Support and preserve home language usage. Whether or not any teachers can speak fluently, programs should make every effort to use children's home language and create environments that reflect children's languages and cultures.
- Develop and provide alternative, creative strategies to promote all children's participation and learning.
- Provide children with many ways of showing what they know and can do.

### **Recommendations for preparation of early childhood professionals:**

- Provide professional preparation and development in the areas of culture, language, and diversity.
- Recruit and support educators who are trained in languages other than English.

### **What is Cultural Competence?**

Cultural competence is a set of matching behaviors, attitudes, policies, structures and practices that come together in an organization to enable that organization to work effectively in cross-cultural situations (Hepburn, 2004; Cross, Bazron, Dennis & Isaacs, 1989). Hepburn defines the following four essential elements for a culturally competent system of care:

- Value, accept and respect diversity.
- Have the capacity, commitment and systems in place for cultural self-assessment.
- Be aware of the dynamics that occur when cultures interact.
- Adapt to make room for diversity.

Correct nutrition is how a child's brain and body grow. Food and mealtime have different meanings in different cultures. In some cultures, certain types of meat are not to be eaten during certain times, or even to be served or offered. Offering a mealtime prayer may be a priority in one family and not considered important in another. One family may feel that continuing to spoon feed a child when they are old enough to do it alone is appropriate and expected. Another family might see that as delaying a child's independence.

As an early childhood professional, culture and how it impacts the care that you provide should always be an influence in your program. Factors to consider are:

- perceptions of time and punctuality
- acceptable personal space
- eye-to-eye contact
- personal hygiene
- acceptable display of emotion
- giving unsolicited advice
- gender roles
- formality in use of names and titles to show respect
- appropriate physical touch
- holiday celebrations
- nutrition
- personal achievement verses the good of the community

Learning about the child's family and culture will increase your cultural competence.

## Professional Development

Working in an early childhood program is not a babysitting job. It is a professional career. Like any other occupation the rules, ideas, and content of the job changes, as do the situations and issues with the children and families. For this reason child care providers should receive current ongoing professional development (training) in child development and early childhood education, and they should remain aware of current community resources.

**Professional development** is defined as ongoing self-assessment of knowledge, skills, and abilities; the establishment of goals; plans for improvement and meeting professional goals.

There are many opportunities for professional development in the state of Oklahoma. It's important to find education that is focused and intentional and one way to do this is by going through The Center for Early Childhood Professional Development (CECPD), a partner agency of the Department of Human Services, Child Care Services. CECPD provides information on training opportunities from basic CPR/First Aid to college courses and the scholarship program REWARD. A Statewide Training Calendar is available along with the Oklahoma Professional Development Registry (OPDR). The Statewide Training Calendar allows a person to look up specific training in Oklahoma that is approved by Child Care Services. The Oklahoma Professional Development Registry allows a person to track that training through an online transcript.

- For more information on professional development go to <http://www.cecpd.org> or call Toll Free: 888-446-7608 or 405-799-6383.
- To enroll in the professional development registry go to <https://okregistry.org/>.
- Each regional child care resource and referral agency (R & R) holds training for child care providers on different topics. You can locate your regional R & R through the Oklahoma Child Care Resource and Referral Association website: [www.oklahomachildcare.org](http://www.oklahomachildcare.org), or call Toll Free: 888-962-2772 or 405-942-5001.



# OKLAHOMA'S EARLY CARE AND EDUCATION PROFESSIONAL DEVELOPMENT VALUES AND IDEALS

## SEEK TO MAXIMIZE PARTICIPATION OF THE FAMILIES OF CHILDREN IN MY CARE

I AM . . .

- Striving to engage families fully in the process of their child's development.
- Showing genuine interest and seeking to understand each family's perspective and history.
- Treating families with dignity by respecting their culture, race and ethnicity.
- Finding innovative ways to include families' informal supports as well as formal community services.

## HONOR CHILDREN'S RIGHT TO SELF-LEARNING

I AM . . .

- Understanding that children are influenced by my attitude and temperament.
- Recognizing that child development is individualized and understanding that children reach developmental milestones on their own timelines.
- Acknowledging that each child has the ability to make his or her own choices.
- Providing children with opportunities to practice making appropriate choices.
- Providing children with a balance between teacher-directed and child-initiated play.

## PRACTICE A HIGH LEVEL OF PROFESSIONALISM

I AM . . .

- Passionate about working with children – continually learning, continually improving.
- Honest with myself about my personal and professional development and willing to learn and grow.
- Seeking help if I have a question about a child's well-being and/or development by consulting available resources, such as the family, my director, the Oklahoma Early Learning Guidelines, Warmline, etc.

## ADVOCATE FOR CHILDREN & FAMILIES, MY COMMUNITY AND CHILD CARE AS A PROFESSION

I AM . . .

- Learning about the internal and external services and supports available to help families.
- Encouraging families to seek and access resources when needed.
- Building trust with families and community partners by working with a high degree of confidentiality and integrity.
- Recognizing the importance of early care and education as a profession and speaking positively about child care's role in the community.
- Raising awareness and generating support for quality child care services.
- A member of an early care and education professional organization such as NAEYC, NAFCC, NEA, NHSA, SECA, ECAO, OCCA, OEA, etc.



## Taking Care of Yourself

Spending your days teaching and caring for young children is a privilege as well as a tremendous responsibility. You have the joy of seeing life through the eyes of children, and you will watch them grow from helpless infancy to more self-sufficient preschoolers, or preschoolers on to being ready for Kindergarten and through the school-age years. You will be a part of their memories forever. In fact, it is while with you that many of their early milestones will be reached. Sounds great right? Then why are you feeling so exhausted?

It is extremely important that as an early childhood provider you make caring for yourself your number one job. If you don't think you have the time, or you aren't worth the effort, just ask the parents how valuable your health and well-being are to them.

### How often do you feel?

- Overwhelmed
- Frustrated
- A lack of pleasure in things that usually bring a smile
- Irritable
- Exhausted or unable to sleep
- Not organized
- Never “caught up”

If you are experiencing any of these feelings on a routine basis, you may have early childhood provider stress. Job related stress affects you and the quality of your work. It's important to learn to manage your stress and find balance in your life. Left unaddressed, these issues may lead to serious health problems and or complete burnout. Here are some steps to take to begin caring for yourself and finding a balance:

- **Health care.** Make time for your annual physical. Be sure that all physical causes are identified and addressed.
  - Could your lack of energy be due to a thyroid problem?
  - Could you be diabetic?
  - Could you have sleep apnea?
- **Regular exercise.** Regular exercise practiced at least three times per week can relax your body and mind. Try walking, swimming, Yoga, or dance lessons.
- **Good Nutrition.** Eating healthy foods helps your immune system work properly and combats the toll that stress can take on your body.
- **Short breaks.** Periodic breaks where you stretch, breathe, or just get a change of scenery can revive your body and lift your spirits.
- **Organize your time.** Attend workshops to improve your effectiveness at work, and take time to indulge in activities that are enjoyable.
- **Create a positive, supportive climate.**
- **Set realistic expectations** for yourself and ask for help when needed.
- **Enroll in a class or workshop** on a subject **NOT** related to early childhood – something that interests you.

- **Meditate, pray**, have “Quiet Time” for yourself.
- **Develop a network of friends who do what you do** – they will understand better than anyone else and you can support each other!
- **Make popcorn**, toss M & M’s in the bowl, **and watch a classic movie**.
- **LAUGH EVERY DAY!** It will change your mood. (Notice how often children laugh and smile!)
- **Go for a walk** with a friend.
- **Get a pedicure** and a manicure.
- **Curl up on your sofa** with a blanket **and read** a great book.
- **Plan short “get away” weekends** or vacations to reduce stress.
- **Make time for your hobbies**.
- Perhaps one of the MOST important ways to care for yourself is to **ASK for help** from a co-worker or friend when you need it. Asking is not a sign of weakness, but of strength.

## **Working with and Including Families**

Communicating with families on a regular basis is important. Child care providers will have a better understanding of children's strengths and needs if they develop a good relationship with the families. There are many ways to build good relationships that will ultimately benefit the children, their families and the child care environment.\*

### **Make families feel welcome**

- Greet families by name when they arrive and tell them about your plans for the day, skills the children are working on or activities the children are involved in.
- Ask parents to share advice with you about their child.
- Develop good listening skills that show parents that their concerns and ideas are important and valid.
- Create a welcoming entrance that allows parents to help their child get settled.

### **Get families involved**

Parents stay better informed and feel more a part of the child care program when there are opportunities for them to get involved. Their involvement helps providers offer a more varied program and children benefit when key adults in their lives take an interest in their activities.

- Have an open door policy so parents feel comfortable dropping by.
- Ask for their assistance with field trips or at fund-raising events.
- Host parent events such as potlucks and children's programs.
- Offer parent education by you and your staff sharing your knowledge, and also by bringing in a speaker for special events or classes.
- Encourage parents to share their skills such as carpentry work and sewing.
- Request donations of items needed for art and science projects, dramatic play areas, music and movement activities, etc. Post a list and update it as needed.
- Get feedback by sending out parent evaluations and having a suggestion box available.
- Form a parent advisory board and solicit their participation and input.

### **Parents bring a unique voice to committees and advisory boards**

- They can participate in parent committees in your program and provide valuable input from a parent's point of view.
- They can share their professional and personal knowledge in areas appropriate to your program (business, marketing, legal matters, fundraising).
- They can participate in community initiatives or organizations as a representative of your program.

### **Communicate with families on a regular basis**

Good communication is the foundation of a strong relationship. Everyone benefits when there is regular communication between child care providers and families.

- Daily communication ideas
  - Verbal communication when children are dropped off and picked up
  - Written communication forms or notes

- Ongoing communication ideas
  - Newsletters • Web site • Bulletin boards • Parent mailboxes • Email • Voice mail • Social Media
- Parent conferences

It's important to schedule conferences at least twice a year to provide parents and early childhood providers the opportunity to discuss development, progress, and goals for the coming year. Develop a formal strategy and share ways to make the child care experience satisfactory.

*Adapted from Child Care Aware of North Dakota <http://www.ndchildcare.org>*

### **Resources for Families**

You can share information with families about their children, your program, and resources that are available to them. The following are examples of communication with families:

- Day-to-day information on children's activities and development
- Regular conferences on children's progress
- Events to showcase children's work
- Newsletters and websites about activities, goals and fun ideas to try at home
- Family education packets (information about Infant Safe Sleep, communicable diseases, age appropriate activities, why children bite and how to discourage it, etc.)
- Information about parenting classes in the community
- Information about community events
- Information about local resources the families may need:
  - Career opportunities or job training
  - Housing assistance
  - Health care
  - Food and resource centers

**If you have a concern you want to discuss with parents think through what you will say and how you will say it.**

#### ***Before bringing up the issue:***

- Identify the real problem.
- What are the consequences of not doing anything?
- What are the consequences of talking with the family?
- What resources can you suggest for the family?
  - Make copies of brochures of agencies that might help.
  - Remember informal resources such as relatives, neighbors, and friends.
- Choose an appropriate time to schedule a meeting with the parent, if possible.
  - The least stressful and hurried time of the day is best.
  - Ask if parent or parents can stop by during their lunch hour, during nap time, or if they can stay a few minutes late when picking up their child.
- Present the problem in a factual way:
  - "I noticed..."
  - Avoid being judgmental.
  - Do not shy away from stating the obvious.

***After stating what you are concerned about:***

- Ask the parent if they have seen a similar behavior or concern.
  - This gives the parent an opportunity to share.
  - This also gives the parent an opportunity to agree or disagree with your concern before you move on to discussing solutions.

***Discuss the concern in terms of how it affects the child:***

- Remember you and the parents are both working toward a common goal; what is best for the child.
- Listen to what the parents say in response:
  - Try to use the same words the parents use as you reply “I hear you saying...is that correct?”
  - This lets the parents know you heard them and value their response.
- Look for a place to compromise.
  - Ask the parent if he or she has ideas for next steps. What can the two of you agree on? What steps or activities can you both work on with the child?

***Remember:***

- You cannot fix things for other people. Your role is to educate parents, provide support, and link them to resources that might be helpful.
- Be sensitive to cultural differences.
- Always end your conversations with parents on a positive note.
- Finally, don't forget to check in. It's important to check in with parents to see how things are going, how the agreed-upon plan is working, and where you might need to make some adjustments.

**Resources to Share with Families**

- **Oklahoma Breastfeeding Helpline:** 24-hour support and information from lactation consultants. 1-877-271-MILK (6455).
- **Oklahoma Domestic Violence Hotline:** Information, counseling and referrals for shelters and services for survivors of rape or domestic violence. Call 1-800-522-7233.
- **Oklahoma Tobacco Helpline:** For free help to quit using tobacco call 1-800-QUIT.NOW (1-800-784-8669).
- **ParentPRO:** For free parenting support call 1-877-271-7611, or visit [www.parentpro.org/](http://www.parentpro.org/).
- **Postpartum Depression Hotline:** For information and referrals to resources and support groups call 1-800-944-4773, or visit [www.postpartum.net](http://www.postpartum.net).
- **211 Helpline:** 24-hour information and referrals for help with utilities, food, housing, job training, etc. Call 211 or visit <http://www.211oklahomahelpline.org>.
- **WIC Hotline:** call 1-888-655-2942.



# Chapter 2: Healthy Living and Health Promotion





## Chapter 2: Healthy Living and Health Promotion

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## Healthy Living and Health Promotion

High-quality early childhood programs focus on improving children's health and promoting development and learning. As early education and child care providers, you play a key role in ensuring that your programs are of high quality and offer safe, healthy, and nurturing environments for young children.

### Environmental Health

Environmental health is the study of how substances or other environmental factors have an impact on human health.

Children live in an environment very different from previous generations. One of these changes is that every day they are exposed to dozens, and sometimes hundreds of chemicals that did not exist 50 or 100 years ago. Unfortunately we don't know much about the health effects of these chemicals, and especially the effects on children's developing systems.

Research shows the first years of a child's life are critical to shaping their future health and development. By reducing toxins and exposure to chemicals you can help prevent illnesses like asthma, lung disease, certain learning disabilities, neurological damage, and even cancer.

Here are some things you can do to improve the environmental health of your program. Many of these recommendations can also be found in *The Eco-Healthy Child Care Checklist* in the Appendix.

### Air Quality

Clean air is a necessity for good health. The Environmental Protection Agency (EPA) says that indoor air can be "more seriously polluted than the outdoor air". [www.epa.gov](http://www.epa.gov)

Here are some steps to improve the air quality:

- Provide as much fresh air as possible in rooms occupied by children. All openings used for ventilation should be screened against insect entry.
- All heating and ventilation equipment, including furnaces and air conditioning units, should be inspected and cleaned before each heating and cooling season.
- Filters in forced-air heating and cooling systems should be checked and cleaned or replaced according to manufacturer's instructions on a regular basis.
- Vacuum, damp mop, and clean regularly to control dust and other contaminants.
- Carbon monoxide detectors should be installed in child care settings if they use any source of natural gas, coal, wood, charcoal, oil, or kerosene.
- Do not allow motor vehicles to keep their engine running in designated parking areas.
- Do not use scented or unscented candles or manufactured air fresheners.
- Do not permit smoking anywhere on the premises or in sight of children, while children are in care.

*(Note: For the healthiest environment for children and staff, smoking should not be allowed on the premises at any time).*

### **Art Supplies**

Art areas should be well-ventilated.

- Use only non-toxic art supplies approved by the Art and Creative Materials Institute (ACMI). <http://www.acminet.org/>
- Materials should be labeled in accordance with the chronic hazard labeling standard, ASTM D4236.
- Prohibit use of unlabeled, improperly labeled old, or donated materials with potentially harmful ingredients.
- Caregivers should closely supervise all children using art and craft materials and make sure they are used properly, cleaned up, and stored in original containers that are fully labeled.
- Children should not eat or drink while using art and craft material.
- Materials should be age-appropriate.
- When using play dough or clay:
  - Children should wash hands before and after use,
  - Sanitize the surface and the tools used before and after each use, and
  - Discard any material that is sneezed upon or put in a child's mouth.

### **Cleaning Products**

- Use biodegradable, non-toxic cleaning products and least-toxic disinfecting and sanitizing products. When other products are required, use only for their intended purpose and in strict accordance with all label instructions.
- Use chlorine bleach only when and where it is required or recommended by state and local authorities. Never use more than necessary.
- Do not use aerosol sprays of any kind.
- Use only low-VOC household paints and do not paint when children are present.
- All cleaning products and paint are stored safely and are inaccessible to children.

### **E-cigarettes/Vapor Products**

- Minors should not have access to e-cigarettes/vaping devices.
- Nicotine present in e-cigarettes can negatively affect the developing brain.
- E-cigarettes/vaping devices contain cancer-causing chemicals (carcinogens) and nicotine.
- Nicotine is as addictive as heroin and cocaine and is toxic at certain doses.
- Nicotine affects the nervous system and heart and can be absorbed into the body through inhalation, ingestion and skin contact.
- Refill cartridges for e-cigarettes with high nicotine content are possibly life-threatening, particularly for children.
- Because e-cigarettes/vaping devices are not regulated, their safety may be questioned.
- Among e-cigarette/vaping devices, the concentration of chemical contaminants and nicotine has been shown to vary greatly. This means these unregulated products may provide uncontrolled doses of harmful contaminants.
- Do not permit vaping anywhere on the premises or in sight of children, while children are in care.

## **Lead**

Lead is particularly dangerous to children because their growing bodies absorb more lead than adults do and their brains and nervous systems are more sensitive to the damaging effects of lead.

### **What is lead poisoning?**

- Lead poisoning is a preventable disease caused by exposure to environmental lead found in lead-based paint, dust, soil, and water.
- It can damage a child's neurological, cognitive, and behavioral development, with irreversible effects.
- Irony: *Nearly all of the lead in our environment, we put there!*

### **What causes childhood lead poisoning?**

- Lead poisoning usually occurs when children ingest dust that contains lead. Children also eat paint chips or soil that contains lead.
- Lead-based paint was banned for use on housing in 1978. Therefore, homes built before that date may contain lead-based paint. Lead-based paint that is chipping and peeling can produce lead dust, which is very dangerous to children.

### **Where is lead found?**

- Lead paint may be found on many surfaces, such as walls, doors, doorframes, windows (wells and sills), woodwork, railings, fences, porches, and stairs.
- Soil and dust can become contaminated with lead. Contaminated soil can be tracked indoors. Children should not play in bare-soil areas that may contain lead.
- Food that is grown in contaminated soil or near buildings painted with lead-based paint may contain lead. Food packaged in imported cans with lead solder seams may also contain lead.
- Water may become contaminated by lead in water pipes, plumbing fittings made of brass or bronze, or lead solder used to connect water pipes (banned in 1986).
- Some ethnic and home remedies and imported cosmetics may contain lead.
- Family members who are oil field workers may come in contact with a threading compound, "pipe dope" that can contain large amounts of lead. If they are not provided facilities to shower and change before leaving work they may be contaminating their home without realizing it.

### **To protect against lead poisoning:**

- Avoid possible lead exposure from water lines. Use only water from the cold faucet for drinking, cooking and making baby formula.
- If the facility was built before 1978 (when lead paint was banned) keep the building free of flaking or peeling paint and regularly wash all areas around doors and windows. Use lead safe practices when removing lead-based paint or when renovating the facility. Visit [www.epa.gov/lead](http://www.epa.gov/lead) to learn more.
- Do not use imported, old, or handmade pottery to cook, store, or serve food or beverages.
- To reduce possible exposure to lead-contaminated dirt, supply a rough mat at the entrance of the facility and encourage the wiping of shoes before entering.

- Check toys for lead by searching [www.healthytoys.org](http://www.healthytoys.org) or by purchasing lead testing kits at a local home improvement store.
- Family members who work with pipe dope should shower, shampoo, and change clothing and shoes before going home.

### **How does nutrition aid in decreasing lead absorption?**

- Lead fools the body into thinking it is iron, calcium, or zinc. This makes the body absorb more lead into the bloodstream.
- Offer children foods high in iron, calcium, and zinc.
- Offer children foods high in vitamin C because it helps the body absorb iron better.
- Offer children fewer high-fat foods. These may increase the absorption of lead.
- Lead is absorbed more quickly on an empty stomach.

### **Mold**

Mold is a fungus that thrives indoors when excess moisture accumulates or remains undiscovered. There are molds that grow on wood, paper, carpet, and foods. Mold needs to be controlled to avoid possible health impacts for infants and children, including allergic reactions, asthma, and other respiratory issues. The key to mold control is moisture control.

- Moist vapor, standing water, and water-damaged materials are a breeding ground for mold, mildew, insects, and bacteria.
- Watch for condensation and wet spots. Fix source of moisture problem as soon as possible.
- Maintain adequate ventilation (suitable fans or open screened windows).
- Repair water leaks and keep humidity within a desirable range (30-50%).

### **Pest prevention and pesticide use**

Diseases that are spread by insects and rodents can be passed to young children. The behaviors that make young children vulnerable to these diseases (crawling and playing on the floor, mouthing toys, etc.) can also expose children to the pesticides that have been applied to control pests. Integrated Pest Management (IPM) is a pest control program that minimizes pesticide exposure and looks for the least toxic alternative. Detailed information can be found about IPM on the California Child Care Health Program website <http://www.ucsfchildcarehealth.org>. The common sense strategies of IPM require the combined efforts of the staff at the early childhood program, as well as the children and parents. The goal is to make the environment less hospitable to pests.

- Only allow food to be eaten in certain areas. Reduce pests' access to food, water, and shelter.
- Empty trash cans at the end of every day.
- Store food in containers with tight fitting lids.
- Clean dishes, utensils, and surfaces soiled with food as soon as possible after use.
- Caulk cracks and openings, and fill in access holes in walls.
- Seal around electric outlets.
- Keep window and door screens in good repair.
- Keep vegetation, shrubs, and wood mulch at least one foot away from all structures.
- Reduce clutter in which pests can hide.

As a last resort, the careful use of pesticides may be necessary.

- Notify parents in advance and have a licensed professional apply the least toxic, effective product at a time when children will not be exposed to the application area for at least 12 hours (see manufacturer's instructions to ensure 12 hours is enough time).
- Use bait, traps, or gels in cracks, wall voids, and in spots that are out of reach of children. Avoid sprays, powders and "bomb" applicators.
- Store all pesticides and toxic chemicals in a locked cabinet.
- Thoroughly wash all fruits and vegetables to avoid possible exposure to pesticides, and take the opportunity to educate children about the importance of doing so.

### **Pet allergies**

- Allergies to pets with fur or feathers are common, especially among people who have other allergies and asthma.
- Dogs and cats shed dander (dead skin) and secrete fluids that contain allergens. Pet hair is not an allergen. It can collect dander, though, and also harbor other allergens like dust and pollen.
- The best treatment is to avoid contact with the pets and their dander.
- Animal allergens are sticky so it is best to remove the animal's favorite furniture, remove wall-to-wall carpet and scrub the walls and woodwork. Keep surfaces clean and uncluttered.
- Inform parents in advance of any pets in the program or planned animal visits to the program.

### **Plastic**

- Do not use infant bottles, plastic containers, and toys that contain Polyvinyl chloride (PVC), Bisphenol A (BPA), or phthalates. Instead buy only those labeled "PVC-free".
- When using a microwave, never heat children's food in plastic containers, plastic wrap or plastic bags.
- Never use baby bottles or sippy cups made of hard clear plastic (bottles labeled #7). Instead use bottle made of opaque plastic or glass. Visit Oregon Environmental Council's website: [www.oeconline.org](http://www.oeconline.org) and type in "safe plastic guide".

### **Radon**

Radon concentrations inside a home or building used for child care must be less than four picocuries per liter of air. All facilities should be tested for the presence of radon.

- Test your facility for the presence of radon. This can be done by using a radon testing kit available from a local home improvement store.

### **Recycling and garbage storage**

- Remove all garbage from rooms occupied by children and staff daily or more often.
- Recycle paper, cardboard, glass, aluminum, and plastic bottles.
- Keep garbage containers (inside and out), covered with tight fitting lids to avoid attracting pests and to minimize odors.

- Outside garbage containers should be constructed of durable material designed and used so animals and pests do not have access to the contents, and so they do not leak or absorb liquids.
- Outside garbage containers should be stored on an easily cleanable surface, in an area that is inaccessible to children.
- Clean garbage cans and dumpsters regularly.

**Education and awareness**

- Create opportunities to educate children and families on the importance of environmental health, and what they can do to help reduce toxins and exposure to chemicals.
- Teach children about the importance of recycling materials and let them assist in the recycling activities of your program.

## **Immunization Information**

### **Child care programs in Oklahoma are required by law to:**

- Enroll children only if they have been immunized, are in the process of being immunized according to state law, or have a state filed exemption form.
- Have a record of all children's immunizations.
- Accept only records signed by a "licensed physician or authorized representative of any state or local department of public health".

### **In order to meet this requirement you will need to:**

- Be familiar with the immunization schedule.
- Set up a file or system for monthly review.
- Communicate with parents when overdue immunizations may require a child to be excluded from care.

**For the most current immunization schedule see the *Child Care Guide to Immunizations in Oklahoma* provided by the Oklahoma State Department of Health (OSDH) Immunization Service at [www.health.ok.gov](http://www.health.ok.gov) .**

### **Who is responsible?**

- Parents are responsible for having their children immunized.
- Child care directors and staff are responsible for following the law by refusing entry to children who do not have immunizations; refer them to their private provider or the county health department.
- Child care licensing staff and health inspectors are responsible for auditing the immunization records to assure compliance with the law.

Children are not in compliance with State law unless they have a certificate of immunization or exemption on file. New enrollees should present evidence of immunization *before* the child is allowed to attend.

### **Immunization records are lost or cannot be found**

If records are not available the child will need to receive immunizations again.

### **The child is sick**

If a physician or public health agency determines a child cannot receive an immunization on time due to illness, a note from that authority must be kept on file at the child care facility. Children should be immunized as soon as they are medically able.

### **Parents who are concerned about side effects**

Always refer these parents to a medical professional who can give them accurate information. They can call any public health agency that gives immunizations.

### **When is a child fully immunized?**

A child who has received the complete "series" of each immunization is fully immunized. For most immunizations, the final dose of the "series" should last for many years.

### **What is “acceptable evidence” of immunization?**

Any record provided by a licensed physician or public health agency that contains the following:

- Which immunizations the child has received.
- The dates the immunizations were given.
- The signature or stamp of the person or agency giving the vaccination.
- Name and date of birth of the child.

### **What about children behind on their immunizations?**

These children may be allowed to attend as long as they are in the process of receiving the immunizations. The parents are required to present a schedule, note, or letter signed by a physician or public health agency that outlines a medically approved timetable for completion of the remaining immunizations. The schedule must be followed or the child should be excluded from the program.

### **Immunization of children over two years of age, who are not up to date**

Refer to the schedules provided by the OSDH Immunization Service [www.health.ok.gov](http://www.health.ok.gov), or you may call the OSDH Immunization Service information at 1-800-234-6196; your local county health department; or your private physician.

### **What about “drop-ins”?**

Drop-ins must also have immunization records before attending an early childhood program.

### Vaccine-Preventable Diseases: The Basics:

- **Chickenpox (Varicella)** is an illness caused by a virus. Chickenpox is usually an illness with a mild fever and a rash. In adolescents and adults however, this virus may produce more serious disease with complications such as pneumonia. Pregnant women who become infected with the varicella virus are at even greater risk for serious complications than other adults, especially late in pregnancy. In addition, infection early in gestation can occasionally produce serious birth defects in the fetus.
- **Diphtheria** is a serious bacterial disease and is spread person to person by infected secretions. Diphtheria can cause blockage of the airway, making it impossible to breathe. It can also cause heart problems.
- ***Haemophilus influenzae* type b (Hib)** is a very serious bacterial disease, which causes about 12,000 cases of meningitis (inflammation of the covering of the brain) in the United States each year. For the most part, this disease affects children under the age of five (children between six months of age and one year of age are affected by the most serious Hib disease). One in four children with the disease suffers permanent brain damage and about one in twenty dies. Other problems caused by "Hib" are pneumonia and infections of the blood, joints, bones, soft tissues, throat, and the covering of the heart. Please do not be confused with the name. "Hib" *does not* have anything to do with the flu (influenza).
- **Hepatitis** is a disease characterized by inflammation of the liver. The symptoms of hepatitis are mild fever, loss of appetite, nausea, vomiting, fatigue, stomach pain, dark urine, and sometimes yellow discoloration of the eyes and/or skin. It should be noted that young children (those under five years of age) may not seem sick or may appear to have a mild illness like "stomach flu" but can still spread the illness to adults. Several viruses can cause hepatitis, but the most common are A and B.

**Hepatitis A virus** is spread from person to person by eating food or drinking water that has been contaminated with human feces. It is estimated that 150,000 people in the United States are infected each year by hepatitis A. The Centers for Disease Control list household or sexual contact, child care attendance or employment, and recent international travel as the major risk factors for Hepatitis A.

**Hepatitis B virus** can cause a serious form of hepatitis. The infection may occur in two phases. The acute phase occurs just after a person becomes infected, and can last from a few weeks to several months. Some people recover after the acute phase, but others remain infected for the rest of their lives. Over half the people who become infected with hepatitis B never become sick, but some later develop long-term liver disease. Hepatitis B is passed from one person to another in blood or certain body fluids. A baby can get Hepatitis B from its mother during birth.

- **Human papillomavirus (HPV)** is a common family of viruses that causes infection of the skin or mucous membranes and is spread through sexual contact. There are over 100 different types of HPV viruses and different types affect different areas of the body.

Some types of HPV cause warts in the genital area and other types can lead to abnormal cells on the cervix, vulva, penis, mouth and throat, sometimes leading to cancer. HPV is considered the most common sexually transmitted disease in the United States. It is the cause of almost all cervical cancers in women and has been linked to the rise of oral health cancers in young people in the U.S.

- **Influenza (flu)** is a highly contagious viral infection of the nose, throat, and lungs. It is one of the most severe illnesses of the winter season, and spreads easily when an infected person coughs or sneezes. Influenza may lead to hospitalization or even death, especially among the elderly. Typical symptoms include an abrupt onset of high fever, chills, a dry cough, headache, runny nose, sore throat, and muscle and joint pain. Because the virus changes, persons can contract influenza each year.
- **Measles** is a highly contagious disease caused by a virus. Symptoms are rash, high fever, cough, runny nose, and watery eyes. Measles can cause serious problems. Nearly one out of ten children with measles will get an ear infection or pneumonia. One child out of 1,000 will develop an inflammation of the brain, which can lead to convulsions, deafness, or mental retardation. One or two children out of 1,000 will die from it. A pregnant woman can experience a miscarriage or give birth too early due to measles.

Immunization for measles has greatly reduced the number of cases occurring in the United States. Ten years prior to the vaccine, an average of 530,000 cases were reported each year in the United States and over 450 people died each year from measles. Today, the number of measles cases is less than five percent of what it was before the vaccine was available.

However, cases continue to occur due to inadequate immunization. Any child who has not been immunized for measles is at risk for getting the disease.

- **Mumps** is another disease caused by a virus. Symptoms of mumps are fever, headache, and inflammation of the salivary glands (this causes swelling of the cheeks at the angle of the jaw). More serious effects from mumps are meningitis (inflammation of the coverings of the brain and spinal cord) which occurs in one out of ten children. Other problems which can occur are encephalitis (inflammation of the brain), deafness, and painful inflammation and swelling of the testicles (one out of every four males).

Before the vaccine, nearly every child got mumps. Because of the vaccine, the number of cases is much lower.

- **Pertussis (Whooping Cough)** is a highly contagious disease. It is caused by bacteria living in the mouth, nose, and throat of the infected person.

Pertussis causes severe spells of coughing which can interfere with eating, drinking, and breathing. Pertussis is most serious in infants less than one year of age, and more than half of the infants reported with pertussis are hospitalized.

Complications are fairly common. One out of every ten children with pertussis will develop pneumonia. Convulsions (seizures) occur in 20 out of 1,000 children. An average of nine deaths a year has been caused by pertussis.

- **Pneumococcal disease** is the leading cause of meningitis, pneumonia, ear infections, and sinus infections. Pneumonia symptoms include high fever, cough with chest pain and mucus, shaking, chills, breathlessness, and chest pain that increases with breathing. Older adults often experience changes in level of consciousness or confusion.
- **Polio** is a very dangerous disease caused by a virus which lives in the throat and intestines of the individual infected with it. Many people can spread the infection to others even though they may not have symptoms of the illness.

Milder forms of polio usually come on suddenly and last only a few days. Although some individuals do not have any symptoms; others may experience fever, sore throat, nausea, headache, stomach ache, pain and stiffness (neck, back, and legs).

"Paralytic Polio" is the serious form of polio and can cause paralysis (inability to move parts of the body). The symptoms are the same as in the milder form; however, they are usually accompanied by severe muscle pain. If paralysis occurs, it does so within the first week. The person may not be able to move his/her arms or legs, and may have difficulty breathing without the help of a respirator, or assisted breathing. There is not a specific treatment for polio and the amount of recovery varies with the individual.

In 1952, the number of cases of paralytic polio in the United States was more than 20,000. Polio has been eradicated from the Western Hemisphere.

- **Rubella (German Measles)** Rubella is usually considered a mild disease of childhood. It is caused by a virus which is spread through coughing, sneezing, or talking.

The usual symptoms are mild discomfort, a slight fever for about 24 hours, and a rash on the face and neck that lasts for two or three days. Young adults may experience swollen glands in the back of the neck and temporary pain, swelling, or stiffness of body joints. Recovery is usually quick and complete.

The biggest concern about rubella is its effect on unborn children; they are in the greatest amount of danger from rubella if their mothers get the disease early in the pregnancy. The chances of such babies being born with birth defects may be as high as 80%. The most common birth defects are blindness, deafness, heart and major artery damage, abnormally small brains and developmental delays.

Immunization for rubella not only protects the immunized child but also protects those not able to be immunized.

**Tetanus (Lockjaw)** is caused by a toxin (poison) produced by a bacteria that enters the body through a cut or wound. Tetanus causes serious, painful spasms of all muscles and can lead to "locking" of the jaw so a person cannot open his or her mouth, swallow, or breathe. Three of ten people who get tetanus die from the disease. Everyone should receive a "Td" vaccine (Tetanus and Diphtheria) every ten years after their last childhood DTP/DTaP or TD.

## Adult Immunizations

### Can adults get sick with "childhood illnesses"?

Yes. Adults who work with children should evaluate their own immunizations with their physician or through a public health agency.

Everyone should receive one dose of Tetanus, Diphtheria, and Pertussis (Tdap) vaccine and a Tetanus and Diphtheria (Td) vaccine every ten years. Some adults may need a Varicella, and Measles, Mumps and Rubella immunization (MMR). **An annual flu immunization is recommended for everyone six months of age and older**, and especially for people who have contact with infants.

### Why should people get vaccinated against the flu?

Influenza is a serious disease that can lead to hospitalization and sometimes even death. Every flu season is different, and influenza infection can affect people differently. Even healthy people can get very sick from the flu and spread it to others. During a regular flu season, about 90 percent of deaths occur in people 65 years and older. The "seasonal flu season" in the United States can begin as early as October and last as late as May.

During this time, flu viruses are circulating in the population. An annual seasonal flu vaccine (either the flu shot or the nasal-spray flu vaccine) is the best way to reduce the chances that you will get seasonal flu and spread it to others. When more people get vaccinated against the flu, less flu can spread through that community.

### How do flu vaccines work?

Flu vaccines cause antibodies to develop in the body about two weeks after vaccination. These antibodies provide protection against infection with the viruses that are in the vaccine. The seasonal flu vaccine protects against the influenza viruses that research indicates will be most common during the upcoming season. Traditional flu vaccines (called trivalent vaccines) are made to protect against three flu viruses; an influenza A (H1N1) virus, an influenza A (H3N2) virus, and an influenza B virus. In addition, some seasons there are flu vaccines made to protect against four flu viruses (called "quadrivalent" vaccines). These vaccines protect against the same viruses as the trivalent vaccine as well as an additional B virus.

## **Nutrition for Young Children**

### **Childhood obesity**

According to the Centers for Disease Control and Prevention (CDC) childhood obesity has more than doubled in children and quadrupled in adolescents in the past 30 years. Childhood obesity has immediate and long-term effects on health and well-being.

#### ***Immediate health effects:***

- High cholesterol and/or high blood pressure – both risk factors for heart disease
- Prediabetes – blood glucose levels indicate a high risk for developing diabetes
- Bone and joint problems
- Sleep apnea
- Social and psychological problems

#### ***Long-term health effects:***

- Heart disease
- Type 2 diabetes
- Stroke
- Osteoarthritis
- Increased risk for many types of cancer

It is important to create an environment and routine that respects children's need for good food and healthy activity from the very beginning. Fighting childhood obesity and raising healthy children requires:

- Healthy nutrition
- Daily active play and movement opportunities
- Reduced screen time

### **Breastfeeding and infant nutrition**

Breast milk provides perfect infant nutrition. Human breast milk is the best food for infants and contains ingredients that formula cannot duplicate. The American Academy of Pediatrics (AAP) strongly recommends breastfeeding as the preferred feeding for all infants through at least the first year of life. It is important to support and encourage breastfeeding in early childhood programs whenever possible.

Many mothers who are breastfeeding want to continue after they return to work or school. Some are fortunate to have child care onsite or nearby so they can continue to breastfeed their baby when needed. For those women who are not able to leave work to breastfeed, breast pumps are a great way to express and save milk for baby to drink when Mom is away.

Many women continue to successfully breastfeed and provide breast milk for bottle-feeding in child care, and they feel good knowing their milk helps keep their babies healthy. The success of this choice depends on the mother and child care provider communicating well and supporting one another. Being separated from “Mommy” can be a difficult adjustment for any infant or child. By being supportive you can help breastfeeding mothers and their babies make this transition.

**Breastfed babies:**

- Receive just the right amount of nutrients needed for a healthy start.
- Have increased bonding time with Mom – breastfeeding satisfies baby’s emotional needs.
- Have better immunity to all types of illnesses.
- Have a reduced risk for allergies and respiratory diseases.
- Have a reduced risk of gastrointestinal illnesses.
- Have a reduced risk of Sudden Infant Death Syndrome (SIDS).
- Are better at eating until their hunger is satisfied, leading to healthier eating patterns.
- Have a reduced risk of obesity, diabetes, and other serious health problems later in life.
- Have also been shown to have higher IQ later in life.

Some breastfed babies do not like using a bottle. Be sure to introduce baby to a bottle before beginning child care. It may be best to have someone other than Mom introduce the bottle, and sometimes it takes a few tries with different nipples and bottles to find what works best.

**Mothers who breastfeed:**

- Have increased bonding time with their babies.
- Have less risk of postpartum depression.
- Have a decreased risk of heart disease.
- Have a decreased risk of breast and ovarian cancer.
- Lose their pregnancy weight faster.
- Are less likely to develop Type 2 Diabetes.
- Save time and money – in the middle of the night breast milk is always ready.

**Mothers who breastfeed can prepare for returning to work by:**

- Practicing expressing breast milk a few weeks before going back to work.
- Collecting breast milk in containers in the amount baby will take at one feeding.
- Labeling each container with baby’s name and the date the milk was expressed.
- Showing the child care provider how baby likes to be held during feedings.
- Tracking baby’s eating schedule to share with the child care provider.
- Introducing a bottle a few weeks before going back to work.

**Child care providers who support breastfeeding:**

- Are caring for infants who are sick less often and therefore they are contagious less often.
- Are caring for infants who spit up less, and their diapers don’t smell as strong.
- Are building a good working relationship with the family from the beginning.

**Steps to a Breastfeeding Friendly Child Care Program**

1. Make a commitment to the importance of breastfeeding.
2. Train all staff in the skills to support breastfeeding, and to properly store, handle, and serve breast milk to infants in care.
3. Provide a breastfeeding friendly environment.
4. Provide a space with a comfortable chair for moms to breastfeed (private if possible).
5. Inform women and families about the importance of breastfeeding.

6. Support breastfeeding employees. Consider applying for the OSDH Breastfeeding Friendly recognition. The recognition period is for three years initially, with the option to renew by checklist confirmation. The *Breastfeeding Friendly Worksite Application for Recognition* can be accessed at <http://bis.health.ok.gov>.

### **What does human milk look like?**

Human milk looks different from formula or whole milk. It is thinner and sometimes has a slightly bluish tint. The fatty part of the milk separates and rises to the top. To blend together again, simply **gently rotate the bottle back and forth**. Babies who are breastfed usually have soft and/or runny stools. This is normal.

### **Handling human milk**

Discuss your program's policy for storing breast milk with the mother, as the guidelines you follow may not be the same as what she is following at home. If the mother has questions about storing and handling breast milk at home, refer her to her health care provider for guidance.

### **Always wash your hands before handling human milk!**

#### **Breast milk should be:**

- Stored in small containers;
- Labeled with the baby's name;
- Dated when milk was collected; and
- Dated when milk was thawed.

#### **Storing and serving breast milk**

- **Always** store breast milk in the refrigerator or freezer.
- Store breast milk in the back of the main body of the refrigerator at **39 degrees or less**.
- Dispose of human milk that has been in the refrigerator for more than 5 days.
- Store frozen breast milk in the back of the freezer at **0 degrees or less**, for 3 – 6 months.
- Use the **first in first out method** when serving breast milk.
- Thaw breast milk in the refrigerator or under running water. Warm breast milk under warm running water or in a pan or warm (not hot) water.
- Bottles of breast milk may also be warmed with a bottle warmer.
- Thawed breast milk may be kept in the refrigerator for up to 24 hours and should **not** be refrozen.
- **Never microwave breast milk or heat it directly on the stove!** Microwaving destroys antibodies in breast milk and can create hot spots that could scald the baby's mouth.
- **Never shake breast milk** as this breaks down antibodies. Since human milk is not homogenized, it will naturally separate when stored in the refrigerator or when defrosting. Our tendency is to shake vigorously, but think carefully about what you are shaking. There are actually live cells and fat molecules in the breast milk that you want to preserve. They are very beneficial for the baby. So rather than shaking, just swirl. Swirling involves gently rolling the container in your palms or holding the container upright and moving it in a circular motion so the milk remixes gently.

### **Feeding the breastfed baby**

- Breast milk is digested more easily than formula, so breastfed infants get hungry about every 1 ½ to 3 hours.
- Do not warm more breast milk than is used for that feeding.
- Start by feeding the baby a small amount of breast milk and add more as needed.
- Hold the baby close and be patient during the feeding. Take breaks for burping, and pay attention to cues.
- Dispose of any unused breast milk left in the bottle within one hour after the feeding.

### **Feeding the formula-fed infant**

- Formula is digested more slowly than breast milk, so formula-fed infants get hungry about every 4 hours or sooner.
- Bottles of formula prepared from powder or concentrate or ready-to-feed formula should be labeled with the child's full name and date of preparation.
- Hold the baby close and be patient during the feeding. Take breaks for burping, and pay attention to cues.
- Dispose of any unused formula left in the bottle within one hour after the feeding.
- Prepared formula that has not been given to an infant may be stored in the refrigerator for 24 hours to prevent bacterial contamination.
- Bottles of formula can be served cold. If you choose to warm them, bottles should be warmed under running warm tap water, or by placing in a container of water no warmer than 120 degrees. **Never microwave bottles of formula!**

### **Pay attention to the cues**

- Infants will give you clues to let you know when they are hungry and when they are full.
- When hungry they will begin rooting and sucking – on hands, fingers, anything they can get to their mouths, and of course they will also cry if food doesn't come soon enough.
- Infants will let you know when they've had enough by turning their heads away.
- Pay attention to these cues and don't try to continue feeding an infant who is sending the message that he is done.

### **First foods**

At about six months (or when the infant's health care provider gives the ok), it is recommended that infants start on solid food, usually iron-fortified cereal. The following are some guidelines from the AAP book *Nutrition: What Every Parent Needs to Know*. Remember that each child's readiness depends on his own rate of development.

**Can he hold his head up?** Baby should be able to sit in a high chair, feeding seat, or infant seat with good head control.

**Does she open her mouth when food comes her way?** Babies may be ready if they watch you eating, reach for your food, and seem eager to be fed.

**Can he move food from a spoon into his throat?** If you offer a spoon of rice cereal and he pushes it out of his mouth and it dribbles onto his chin, he may not have the ability to move it to the back of his mouth to swallow it. This is normal. Remember, he's never had anything thicker than breast milk or formula before, and it may take some getting used to. Try diluting it the first few times, then gradually thicken the texture, or wait a week or two and try again.

**Is she big enough?** Generally, when infants double their birth weight (at about 4 – 6 months) and weigh about 13 pounds or more, they may be ready for solid foods.

**NOTE: the AAP recommends breastfeeding as the sole source of nutrition for baby for about six months, and continuation of breastfeeding until at least 12 months.**

Don't be surprised if most of the food winds up on baby's face, hands, and bib during the first few feedings. Start with just a teaspoon or two and increase the amount gradually as baby learns to swallow solids.

**REMEMBER:**

1. If the baby cries or turns away, do not make him eat.
2. Never put baby cereal in a bottle.

**NEVER feed honey to an infant.** Honey is a sweetener that must never be given to, or used in foods for children under one year of age, as it may contain botulinum spores which can cause deadly botulism. It is also recommended that corn syrup and maple syrup not be given to or used in foods for infants, since studies regarding their safety for this age group are still inconclusive.

**Finger foods**

Once an infant can sit up and bring hands or other objects to the mouth, you can offer some finger foods. To avoid **choking**, make sure anything you give baby is soft, easy to swallow, and cut into small pieces. Some examples include:

- Small pieces of banana
- Wafer-type cookies or crackers
- Scrambled eggs
- Well-cooked pasta
- Well-cooked chicken finely chopped
- Well-cooked and cut up yellow squash, peas, and potatoes

It is important for babies to get used to the process of eating – sitting up, taking food from a spoon, resting between bites, and stopping when full. These early experiences will help them develop good eating habits throughout life.

## Child Nutrition

### One year olds

Toddlers need fat in their diets to ensure proper growth and brain development. Dietary fat also provides energy, promotes wound healing, and helps young children absorb certain vitamins. Children between 12 and 24 months of age should be served whole pasteurized milk or breast milk in a cup if the mom continues to supply breast milk.

By a child's first birthday, he should be able to handle most of the foods served to the rest of the family – but with a few precautions.

1. Be sure the food is cool enough so it won't burn.
2. Avoid heavily spiced, salted, buttered, and sweetened food.

3. To avoid choking – make sure every food is mashed, or cut into small, easily chewable pieces, and teach young children to finish a mouthful of food before speaking or taking another bite of food.

### **Two year olds**

At age two a child can use a spoon and fork, eat a wide variety of finger foods, and drink from a cup with just one hand. Because two year olds may gulp their food when they're in a hurry to get on with playtime, the risk of choking is high. Maintain the "stay seated when eating" rule and avoid the following foods which could be swallowed whole and block the windpipe:

- Hot dogs (unless sliced lengthwise, then across)
- Whole raw carrots
- Cherry tomatoes (unless cut in quarters)
- Raw celery
- Spoonful of peanut butter
- Nuts (especially peanuts)
- Raw cherries with pits
- Round, hard candies or gum
- Whole grapes
- Marshmallows

### **Feeding preschool-age children**

Preschoolers grow in spurts, so their appetites also come and go. There is no cause for concern. A growing, energetic child will not starve. Remember to offer healthy food frequently.

Attitudes formed about food and eating during the preschool years will be carried into adulthood so be sure to:

- Promote healthy eating practices.
- Enforce rules about acceptable eating behavior (preschoolers like rules even though they may resist them at times).
- Let preschool-age children help with food preparation when possible.
- Preschool-age children are more aware of the appearance of food, so remember to serve meals with a variety of colors, shapes, and textures.

### **Healthy eating habits**

#### **1. Follow a meal and snack schedule**

- Plan for 3 meals and 1 or 2 snacks each day (24 hours). When serving meals to children in child care – for the Child and Adult Care Food Program (CACFP) serve two meals and one snack, or one meal and two snacks for each full day of care.
- Some child care providers will provide an extra snack that is not reimbursable because they know the children need it, or they may serve an unplanned healthy snack to a child that says he is hungry (we want them to recognize when they are hungry or full).
- Make sure the foods offered at each meal and snack help meet the children's nutritional needs. (No cookies, chips, or other empty calories served in between meals and snacks.) Refer to the *Healthy Eating and Daily Food Plan* in the Appendix.
- Set reasonable limits for the start and end times of meals.

**2. Serve and eat all meals and snacks at the table**

- Some meals and snacks may be served at a favorite outdoor table or sitting on a blanket, but develop the healthy habit from the time children are infants of sitting down together when eating and drinking. No roving grazers!
- No carrying the “sippy cup” everywhere – hanging from the child’s mouth!

**3. Offer a variety of foods**

- Offering a variety of foods helps children get the nutrients they need from every food group, and helps you meet the CACFP requirements.
- Vary the types of cereals, breads, and pastas you serve with your approved meals.
- Add different ingredients to your typical salads and sandwiches.
- The food you prepare and serve can provide many learning opportunities.

**4. Start with small portions**

- Invest in child-sized bowls, plates, and utensils that are easy for the children to handle.
- Serve small portions. Large portions on large plates overwhelm children to the point where they may not even take a bite.
- For babies and toddlers who can’t serve themselves, serve only a small amount of new foods so they’re not overwhelmed.
- As children are able, starting around 2 ½ years, they can begin learning to serve themselves. (Family Style Dining!)
- Teach them to take small amounts at first. Tell them they can get more if they are still hungry.
- Don’t insist children eat all the food on their plate. When we were younger, cleaning the plate was a must for many of us, but making kids eat every last bite actually does more harm than good.
- Let them know it is ok to eat as much as he or she feels like at the time.

**5. Help them try new foods**

- Children are often hesitant to try new foods. Offer only one new food at a time. Serve it with familiar foods the children like.
- Serve small portions of the new food and urge the children to take a test taste or a “*no thank you*” bite.
- Offer a new food many times. Studies show it can take between 10 and 15 tastes of one type of food before a child accepts or likes it.
- Be a good role model by trying the new food. Describe its taste, texture, and smell.

**6. Teach children to know when they’ve had enough**

- Infants will let you know when they’ve had enough by turning their heads away. Pay attention to these cues and don’t try to continue feeding an infant who is sending the message that he is done.
- Help children learn to keep listening to their bodies as they grow. Kids who listen to their bodies stop eating when they’re full and are less likely to become overweight.
- Let children learn by serving themselves.

- Avoid praising a clean plate. A child should stop eating when he or she is full, rather than when the plate is clean.
- Never use food as a reward or a punishment!

### **7. Set a good example**

- Eat with the children and let them see you choosing and enjoying a variety of nutritious foods.
- Be willing to try new foods.
- Include children in food preparation and cooking activities.
- Keep things positive.

### **8. Make mealtime fun**

- Create a positive, calm eating environment.
- Focus on the meal and each other. No TV! No Phone!
- Help children develop the art of conversation. Talk about what you've done so far that day, talk about plans for the rest of the day and week. Ask questions and allow time for each child to answer:
  - What made you laugh today?
  - What is your favorite bedtime or naptime book?
  - If you could be an animal for one day – what would you be?
  - What's your favorite vegetable? Why?

### **Child and Adult Care Food Program (CACFP)**

Many licensed child care programs participate in the CACFP. The CACFP reimburses programs at free or reduced-price rates for eligible meals and snacks served to enrolled children, targeting benefits to those children most in need. The programs must serve meals that meet the meal pattern requirements. The meal patterns give guidance on the number of components and amount of food which must be served to receive reimbursement. Visit the U.S. Department of Agriculture website, [www.fns.usda.gov](http://www.fns.usda.gov) and search for Child and Adult Care Food Program for a good source of child nutrition information. Also see *Child Care Meal Pattern* in the Appendix.

### **Family Style Dining**

In family style dining, all food is placed on the table in child size serving bowls, with child size serving utensils. Children are encouraged to serve themselves, with help from their teacher if needed. Milk can be served in small pitchers or cartons so children can learn to pour their own.

Family style dining helps children learn and practice many different skills. They learn social skills, such as sharing, taking turns, and manners – saying please and thank you. Family style dining also gives children the opportunity to develop their gross and fine motor skills by helping to set the table, pouring their own milk, and learning how to serve themselves without touching the food in the serving bowls.

Family style dining allows children to feel in control of their eating. They know that they can decide what to eat and how much to serve themselves. Children may take a small serving, or they can pass on certain foods, but change their minds later in the meal. With family style

dining, child care providers act as role models during mealtime. They sit and eat with the children and demonstrate healthy eating habits and appropriate table manners.

Indirectly, family style dining encourages children to try new foods. While children may need to be offered a new food 10-15 times before they will try it, they often follow what they see others doing. They are more likely to try new foods if other children or the adult sitting with them are eating these foods.

#### **Steps to plan and prepare for Family Style Dining:**

1. Begin by setting a start date. During this time research family style dining and create a plan for implementing it in your program.
2. Buy supplies for meal service. Purchase serving bowls, spoons, utensils, and pitchers that children can easily use.
3. Train employees. It is important that all staff members receive training and have a willingness to carry out family style dining.
4. Educate parents and children. Explain the benefits to parents, providing printed materials with information for them. Display a table with family style supplies for parents to view. Then begin introducing family style dining to children.
5. Begin a pre-meal routine and have a responsibility for everyone.

#### **Healthy menu planning**

Develop a cycle menu to follow. A cycle menu is a series of daily menus for a set length of time, such as three weeks. Each menu in the series is different. After the series has been served, it is repeated, beginning the cycle again.

#### **How to get started:**

- Decide on the number of weeks for the cycle (If you're enrolled in the CACFP get a copy of the Meal Pattern requirements).
- Choose the main dish for each day of the cycle.
- Try to plan a different main dish for each day of the cycle, alternating between types of meat or protein.
- Add the vegetables, fruits, and grains.

#### **Tips**

- Include foods that are in season. The cycle menu can be adjusted for seasonal produce.
- Balance, over a week, higher-cost foods with lower-cost foods.
- Vary the shapes, colors, temperatures, textures, and flavor of foods in the meals.
- Include raw and cooked vegetables.
- Include a variety of foods so children get a wide range of nutrients.
- Try some new recipes along with the standard ones.
- Cycle menus can also be adjusted to allow for holidays and unexpected leftovers.
- Consider when fresh foods will arrive and how long they will last.
- Consider delivery times and storage capacities of freezers and refrigerators.

**Menu planning checklist:**

- Does the menu meet the CACFP requirements of the day for all children?
- Is a good source of vitamin C included?
- Is a good source of iron included?
- Is a good source of vitamin A included?
- Does each meal include foods with different textures?
- Does each meal include foods with different colors?
- Is a new food included along with some favorite foods?
- Are some foods that represent the culture of the children included?
- Are food safety standards followed for the ages of the children?
- Are you serving a variety of fruits and vegetables?

**Nutrition Checklist**

**Infant feeding**

- Infants are fed only human milk or formula, never cow's milk.
- Infants are fed when hungry and allowed to stop feeding when showing signs of fullness.
- Caregivers and teachers hold infants for bottle-feeding.
- Mothers are encouraged to breastfeed on-site, and breastfeeding families are welcomed.
- Infants are not fed solid foods in a bottle or infant feeder.
- Infants are offered solid foods around six months of age, or a little sooner if recommended by the infant's health care provider.
- Infants are not served fruit juice or water.
- Infants are never fed HONEY.

**Feeding young children**

- If serving fruit juice, children are at least 12 months of age and are served 100% full strength fruit juice in small amounts, with a limit of 4 – 6 ounces per day.
- Children are not served concentrated sweetened foods or drinks (e.g., candy, fruit punch, lemonade, or soft drinks).
- Menus provide age-appropriate whole grains, vegetables, fruits, chicken, fish, and beans, and avoid salty and fried foods.
- From the age of two, children are served skim or 1% pasteurized milk.
- Clean and sanitary drinking water is readily available throughout the day and the children are encouraged to drink it.

**Nutrition plan**

- Written menus and food guidelines are in place.
- Children are served age appropriate portions that meet national requirements (Child and Adult Care Food Program).
- Toddlers and older infants are encouraged to feed themselves. Caregivers sit with them and supervise their use of child-sized cups, spoons, forks, and fingers.

**Behavior and socialization**

- Mealtime is relaxed and enjoyable – a time when adults and children talk together and share conversation and learning opportunities.
- Older children are involved in serving food as well as setting and cleaning tables.
- Children are not forced or bribed to eat (food is not used as a reward or punishment) and eat only when seated.

*Checklist adapted from the Family Checklist for Nutrition in Early Care and Education developed by the National Resource Center for Health and Safety in Child Care.*



## Oral Health

### Developmental Stages and Concerns

#### Did you know...

- Dental cavities are the most common childhood disease?
- Dental cavities are largely preventable through proper nutrition, feeding practices, oral hygiene and fluoride?
- Dental diseases can interfere with speaking, eating, sleeping and learning?
- Germs that cause cavities can pass from adult to child?
- Caregivers should lift the lip of children to check for dental problems?
- **Oral health is essential to overall health?**

#### Infants 0-6 months

- Infants need a proper diet for the development of healthy teeth and gums, and for general good health.
- Breast milk is the most complete and preferred form of nutrition.
- Ready to feed formula or formula concentrate mixed with water are other choices. It is fine to use fluoridated tap water or nursery water when mixing formula.
- Clean babies' gums daily with a soft, clean, damp cloth or a gauze.
- Hold babies while feeding them – never put them down to sleep with a propped bottle or with the baby holding a bottle.
- Use only clean pacifiers, rinse with water.

#### Babies 6-12 months

- Teeth begin to erupt (come into the mouth) at about 6 months.
- As teeth erupt, a cool teething ring or cold cloth may soothe sore gums.
- As with the younger infant, never put a baby to sleep with a bottle or sippy cup. Liquids such as milk and juice pool around the teeth when a baby is lying down. The beverages bathe the teeth with constant contact and may cause early childhood caries also known as baby bottle tooth decay.
- Clean these first teeth gently with a damp cloth. Fluoride varnish can be applied to baby teeth by a physician or dentist to help prevent decay.

#### Toddlers 1 and 2 year olds

- By age 1, take children off the bottle and introduce a cup without a lid.
- Limit juice – only 4 ounces per day.
- If a sippy cup is used it should only contain water. Fluoridated tap water helps protect teeth from decay.
- Lifting the lip will allow the caretaker to check teeth for white spots or discoloration, which are signs of early decay.
- At this age, introduce a very soft children's toothbrush. Use a small smear of fluoridated toothpaste once the child can spit.
- Toddlers want to brush on their own and should be encouraged to do so, however – it's essential that a caregiver gently brushes the teeth for them also.

- Brushing before going to bed is the most important time to prevent dental diseases.
- Fluoride varnish can be applied to the teeth to protect against dental decay. The first dental visit may occur at this age.

### **Preschool 3, 4 and 5 years olds**

- By age 2½ to 3, all 20 baby (primary) teeth have erupted in the mouths of most children.
- It is normal and desirable to have spaces between baby teeth to allow room for larger adult (permanent) teeth.
- The first adult teeth usually erupt around age 6.
- Practice brushing with preschoolers, making sure to gently brush all teeth surfaces and around the gum line. Continue to assist and monitor a child's brushing until they are capable of brushing properly on their own (6 – 8 years old).
- Use a small amount of fluoridated toothpaste.
- Teeth should be brushed gently at least twice daily, in the morning and at night before going to bed.
- A healthy diet is very important in preventing dental decay: limit juice and sugary snacks, provide wholesome foods, and encourage drinking water.
- Preschool children should visit a dentist.
- Children learn oral habits early – so be a good example and a patient teacher.

## Early Childhood Caries (Baby Bottle Tooth Decay)



Healthy gums and teeth. Spacing is desirable!



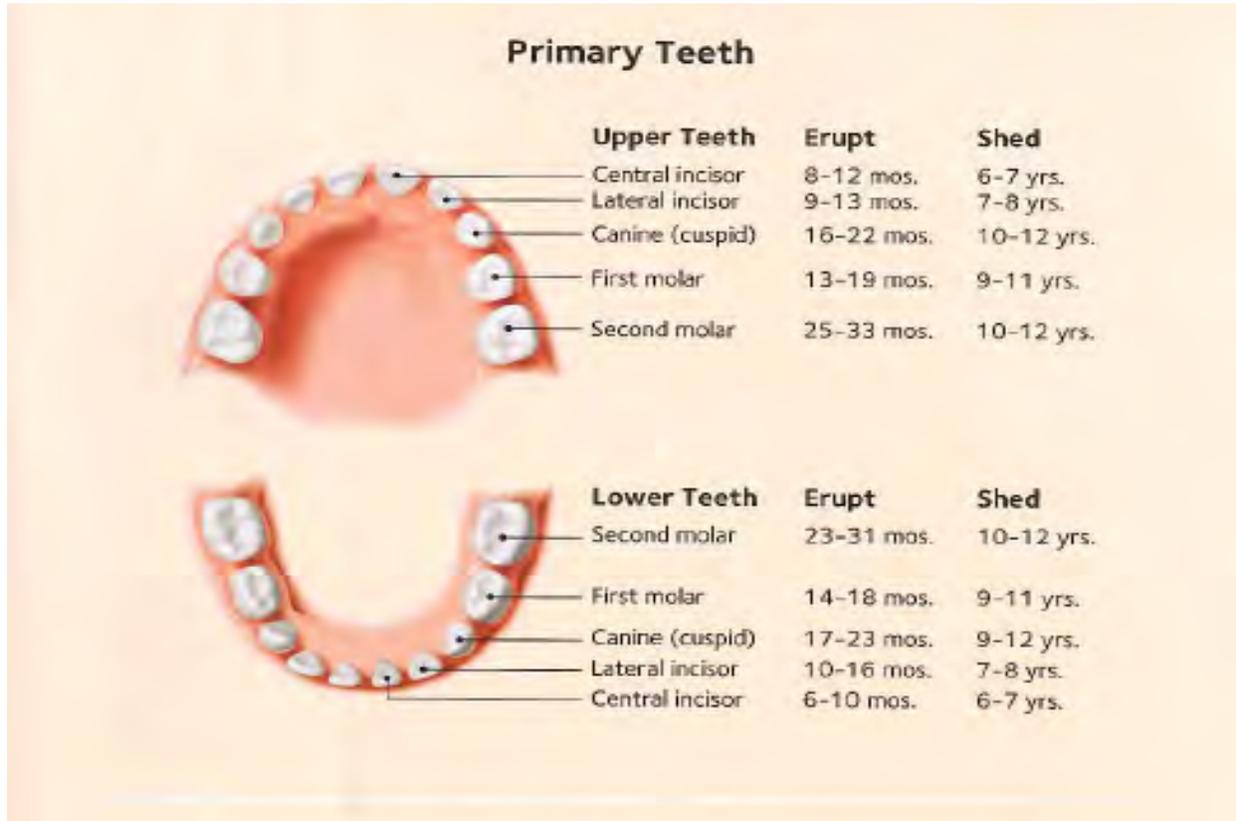
Brown Spots – needs dental care referral.



Severe Decay – risk for infection; often requires general anesthesia in the operating room.

American Academy of Pediatrics (2010), A Pediatric Guide to Children's Oral Health

## Eruption Chart for Primary (Baby) Teeth



American Dental Association (2012), Your Child’s Teeth

## Helpful Links

**American Dental Association site for babies and kids**

<http://www.mouthhealthy.org/en/babies-and-kids/>

**American Academy of Pediatrics site for children’s oral health**

<http://www.mychildrensteeth.org/>

**Crest: Education, curriculum, games and videos for children**

<http://dentaeducation.crest.com/>

**Colgate: Games and videos for children, information for caregivers**

<http://www.colgate.com/app/BrightSmilesBrightFutures/US/EN/HomePage.cvsp>

**Sesame Street: Healthy Teeth, Healthy Me: Brushy Brush PSA video**

<https://www.youtube.com/watch?v=wxMrtK-kYnE>

**If You’re a Kid Dental Health Remix dance video**

<https://www.youtube.com/watch?v=mYRlCTyoelw>

**Maternal and Child Health resources**

<http://www.mchoralhealth.org/>

**Guide to Free and Low-Cost Dental Care in Oklahoma**

[https://sites.deltadentalok.org/site\\_docs/DDOK\\_FND\\_ResourceGuide\\_LR.pdf](https://sites.deltadentalok.org/site_docs/DDOK_FND_ResourceGuide_LR.pdf)



## Provide Oral Health Care in Early Childhood Settings

Brushing teeth should be a part of every child's daily routine from an early age. This can be done after breakfast and lunch, or just once a day if that works best for your program. Make this time fun and reinforce with learning activities.

Supplies needed:

- Individual, permanently marked, soft bristle toothbrush for each child.
- An area to store toothbrushes that allows space for them to air dry without touching and with minimal exposure to contaminants. **See Appendix for *Toothbrush Storage ideas*.**
- Toothpaste with fluoride for children two years and older.
- Individual paper cups for rinsing.

Directions:

1. Children wash hands and get their individual toothbrush.
2. Provide a tiny smear of toothpaste for each child – either on a square of waxed paper or on the edge of their paper cup.
3. Children begin brushing on their own, then provide assistance where needed.
4. Children rinse and spit, clean up, and return their toothbrush to storage.

Encourage and promote good oral health through **reading children's books** about caring for teeth, losing a tooth, and going to visit the dentist:

- *Doctor De Soto* by William Steig
- *ABC Dentist: Healthy Teeth from A to Z* by Harriet Ziefert
- *Open Wide: Tooth School Inside* by Laurie Keller
- *Dear Tooth Fairy* by Pamela Duncan Edwards
- *Food for Healthy Teeth* by Helen Frost
- *Brush Well: A Look at Dental Care* by Katie S. Bagley
- *Loose Tooth* by Lola M. Schaefer

Also **try these fun tooth brushing songs:**

### **To the tune of *Twinkle, Twinkle, Little Star***

*Got my toothpaste, got my brush  
I won't hurry, I won't rush.  
Making sure my teeth are clean  
Front and back and in between.  
When I brush for quite a while  
I will have a happy smile!*

### **To the tune of *Wheels on the Bus***

*This is the way we brush our teeth, brush our teeth, brush our teeth,  
This is the way we brush our teeth, after every meal.*

**To the tune of *I've Been Working on the Railroad***

*I've been brushing with my toothbrush,  
Brushing every day  
I've been brushing with my toothbrush,  
It's how I fight decay.  
All my teeth are gonna sparkle,  
How proud I will be.  
Every time I want to smile,  
My teeth will shine for me!  
Always brush your teeth,  
Every single day.  
Keep those cavities away!  
Use your brush and paste,  
Just the way you should,  
Keep your smile a-lookin' good!*

**Flossing activity:**

Make a flossing puppet out of a plastic milk jug: Cut a hole for the mouth and make slits to create teeth. The children then use real floss to practice flossing the puppet's teeth. Add silly yarn hair and big funny eyes so the children really like the puppet itself and are eager to help him learn to "take care of his teeth!"



Brush EVERY DAY to  
keep your teeth healthy!

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## Teething

The teething process can begin as early as 3 months and continue until a child's third birthday. Typically between the ages of 4 and 7 months, a child's first tooth will push through the gum line. The first teeth to appear are usually the two bottom front teeth, also known as the central incisors. These are usually followed 4 to 8 weeks later by the four front upper teeth (central and lateral incisors). About 1 month later, the lower lateral incisors (the two teeth flanking the bottom front teeth) will appear. Next to break through the gum line are the first molars (the back teeth used for grinding food), then finally the eyeteeth (the pointy teeth in the upper jaw). Most children have all 20 primary teeth by their third birthday. In some rare cases, children are born with one to two teeth or have a tooth emerge within the first few weeks of life. Unless the teeth interfere with feeding or are loose enough to pose a choking risk, this is usually not a cause for concern.

### Easing teething

Whenever a child begins teething, he or she may seem to drool more, and want to chew on things. For some babies, teething is painless. Others may experience brief periods of irritability, and some may seem cranky for weeks, experiencing crying episodes and disrupted sleeping and eating patterns. Although tender and swollen gums could cause a baby's temperature to be a little higher than normal, teething as a rule, does not cause high fever or diarrhea.

Tips to keep in mind when baby is teething:

- Teething may cause increased drooling, a desire to chew, and/or mild gum discomfort. Give baby something to chew on. Make sure it's big enough so that he or she can't swallow it, there are no sharp areas and that it can't break into small pieces. A wet washcloth placed in the freezer for 30 minutes makes a handy teething aid. Be sure to launder after each use. Rubber teething rings are also good, but it is recommended to avoid those with liquid inside because they may break. Take teething rings out of the freezer before they harden too much – this can bruise already swollen gums.
- Wipe baby's face often with a cloth to remove the drool and prevent rashes from developing.
- Rub baby's gums with a clean, gloved finger.
- Never tie a teething ring around a baby's neck due to strangling danger.
- Give pain relief medications with written parental permission only.

Usually there is no need for special medications, such as numbing gels or pain relievers. If a child is acting ill or has a temperature above 100.4 degrees, notify the parents. The child may need medical evaluation.



## Physical Fitness

### *Let's Move!*

First Lady Michelle Obama coordinated the creation of *Let's Move!* – a national campaign that tackles the challenges of childhood obesity. It's no secret that today's youth eat more, and a lot of the food they are consuming is unhealthy. Children are also less active than ever before.

*"In total, we are now eating 31 percent more calories than we were forty years ago—including 56 percent more fats and oils and 14 percent more sugars and sweeteners. The average American now eats fifteen more pounds of sugar a year than in 1970."* (*Let's Move!* [www.letsmove.gov](http://www.letsmove.gov))

Children are also given less opportunities to play, or be active in everyday life. Electronics like television and smart phones can keep children from getting out and moving – something their bodies desperately need. Healthy living is more than exercise or a diet; it is a complete lifestyle change that takes work to adopt. If we start early with our children, we can ensure that future generations will grow healthier and therefore happier in whatever they choose to do.

Find out how well you already incorporate healthy living habits by completing the *Let's Move! Child Care Checklist* in the Appendix.

Ways to incorporate healthy living into your curriculum:

- Play and dance both inside and outside.
- Serve nutritionally appropriate meals and snacks.
- Have discussions about healthy living with the children (of all ages).

Providers can begin teaching healthy living habits with even the youngest children. Providing an infant or toddler with a whole-wheat cracker or a safe piece of fruit instead of a fatty snack is the right direction to move in. Educating parents on what their children are eating both while in care and at home can help parents learn about living a healthier lifestyle with their children.

Younger children need time to be active. Moving around with even your youngest babies is a great way to introduce physical activity. Infants should be provided time for exploring when awake, both indoors and outdoors, with very limited time spent confined in a swing, infant seat, or stationary activity center.

The *Let's Move! Child Care* lists goals for amount of active play by age groups:

- Preschoolers need two or more hours of active play time each day.
- Toddlers should have at least an hour of active play time each day.
- Babies should have short periods of "tummy time" every day if they aren't able to roll over yet, and time to play and move on the floor unrestricted for the majority of their waking hours.

Children mirror what they see every day, so if their own teachers aren't practicing these concepts the children will not follow. The entire *Let's Move!* Campaign is set up for the participation of both children and adults.

More simple steps to participate in *Let's Move!*

- Run around the playground with the children.
- Set up obstacle courses indoors and out for you and the children to practice body movement and control.
- Play different types of music and dance. This is a great opportunity for children to begin hearing the differences in music and learning about rhythm and beat, as well as learning to control the motion of their bodies. Music and dance can lead to many creative movement experiences as well as open-ended questions. "What do you hear when I play this song?" "How is it different from the last one?" How does it make you feel?"
- Make healthy decisions about the food and drink you consume.
- Include children in a gardening project and food preparation when possible.

Learn more about healthy lifestyle changes by visiting the following websites:

[www.letsmove.gov](http://www.letsmove.gov)

<http://www.choosemyplate.gov/>

<http://www.youarewhatyoudrink.org/>

## **Outside play**

Outside play is vital to a child's development. Playing outside can improve physical, mental, and emotional health. Outdoor play helps kids maintain a healthy weight, boosts their immunity and bone health and lowers stress. When children spend less time outside they are more likely to become obese, or dislike and even fear the outdoors. They may have behavioral problems that require medication. Children do more than exercise their physical bodies when they play outside. They learn about science, music and movement, and language while improving observation skills and visual-spatial skills, just to name a few.

Children enjoy playing outside. They have energy stored up making this the perfect opportunity for them to run, jump, yell, throw safe toys, and burn off that energy. When children are doing all of those "outside only" activities they are pumping their arms and legs, working their vocal chords, sweating, and truly giving their bodies much needed exercise. As with any type of physical activity providers should encourage children to drink water while playing. Safe drinking water should be available and accessible during outside play.

Outside play can be a directed activity or free play. Both are equally important. When providers play outside with children they can encourage them to use their gross motor skills by teaching them to skip, jump, run and walk backwards and do these activities with them. Providers can help strengthen children's imaginations by having them act out animals, trees, or vehicles like trains or airplanes. Providers can also allow children to discover what they can do on their own through free play which allows children to make their own choices. Free play outside also allows children to learn about the world around them by exploring nature. Providers should always stay close by to supervise, discuss with the children what they are doing, and answer questions the children may have.

**Outside play tips:**

- Children are always learning so point out trees, grass, and flowers, saying the words for each object several times. Even babies and young children who cannot speak are absorbing everything they hear and see.
- Float like butterflies, hop like bunnies, flap your arms like birds, jump like frogs & slither like snakes to encourage imagination and physical activity.
- Think outside the box when playing outside, read to the children, paint, blow bubbles, or sing and dance on the playground.

**Weather**

It is important that children get outside every day that weather permits, even if it's just for a few minutes during warmer or colder temperatures. Children need the opportunity to exercise their muscles and stretch their limbs; this is a vital part of their development. Infants and toddlers can go outside right away as long as there are no health issues the child's health care provider has discussed with the adults in the family. Babies are soothed by white noise; this is especially true with young infants. White noise is similar to what babies hear in the womb. The outdoors has natural white noise – like the wind in the trees, the birds singing, or a babbling brook.

**Outdoor play should be part of the daily schedule throughout the year.**

Children are happier, healthier, and stronger when they play outside regularly. According to an article in the July 2010 Harvard Health Letter, sunlight lifts spirits, reduces stress, and boosts vitamin D, which is important in immune function. The journal *Pediatrics* reports that 70% of American kids are not getting enough vitamin D, which can lead to a host of health issues.

According to research (Fjortoft 2004; Burdette & Whitaker 2005) children who play outdoors regularly:

- Become fitter and leaner.
- Develop stronger immune systems.
- Have more active imaginations.
- Have lower stress levels.
- Play more creatively.
- Have greater respect for themselves and others.

Time spent outdoors is also shown to reduce myopia (near sightedness) in children (*Optometry and Vision Science, 2008*).

**Outdoor play – it's not just FUN, it's good for you!**

In the cold weather if children are dressed properly they can still enjoy the outside for a short while; during hot temperatures wear protective clothing as well. It's a good idea to keep some spare clothing at the child care facility in case children do not come to school dressed appropriately for outdoor play. Keeping a few coats, sweaters, hats, sets of gloves, as well as shorts, and T-shirts will help keep children playing comfortably outside.

Providers should be aware of terms like “wind chill” and “heat index” as well as the different types of weather watches and warnings when children are playing outside. More information about weather definitions can be found on the National Weather Service Website (<http://www.weather.gov>).

**Heat index:** how hot it *feels* outside in comparison to the actual temperature.

**Wind chill:** the measure of wind speeds which factor how cold it can *feel* outside.

**Weather watch:** the risk of hazardous weather is possible in your area.

**Weather warning:** the risk of hazardous weather taking place in your area is very high.

**Weather tips:**

- Limit time spent outdoors when the temperature/wind chill drops below freezing (32°) or the temperature/heat index is above 90°.
- When the weather is cold it is best to wear layers of loose-fitting lightweight clothing. Jackets and coats should be water repellent when rain or snow is present.
- In addition to their layered clothing, children should wear a hat, coat, and mittens or gloves snug at the wrist when going out on a cold day.
- When the weather is hot and sunny children should be protected from the sun by using shade, sun-protective clothing, and sunscreen.
- Take advantage of shaded areas during the hottest part of the day (10AM-4PM) as much as possible, and use a sunscreen with UVB-ray & UVA-ray protection of SPF 15 or higher specially formulated for children, with parental permission.

The National Weather Service (NWS) provides convenient color-coded guides for caregivers/teachers to use to determine which weather conditions are comfortable for outdoor play, which require caution, and which are dangerous. These guides are available on the NWS Website at <http://www.nws.noaa.gov/om/windchill/index.shtml> for wind chill, and <http://www.nws.noaa.gov/om/heat/index.shtml> for heat index.

**Safety**

Always provide proper supervision when children play outdoors. Carefully maintain all equipment, and make sure swings are made of soft materials such as rubber, plastic, or canvas. Keep play areas free from debris and animal waste. Walk through the play space before the children go outside to ensure there is no garbage, scattered debris, or broken toys or equipment.

Children will fall, this is inevitable; be sure there is some sort of cushion under playground equipment, especially any equipment children climb on. Grass, concrete, asphalt, and dirt are not acceptable surfaces underneath playground equipment. A one foot fall onto concrete can cause a concussion. Loose materials such as sand, pea gravel, wood chips, or rubber chips provide a safe surface for falls, but should not be used on playgrounds intended for toddlers.

When supervising children outside, teach them how to be safe on the equipment provided. Provide helmets and enforce the “must wear a helmet to ride” rule for all children riding tricycles, bicycles, skateboards, and scooters. Make sure enough teachers are outside in case an emergency takes place. Keep in mind the ages of the children, the adult to child ratios, and the types of toys and equipment they are using. All equipment should be in good condition and age appropriate.

**Safety Tips:**

- Darker surfaces can become hot under intense sunlight, so consider using lighter colored materials or providing shade to prevent burns to exposed skin.
- Periodically seal, stain, or paint wooden equipment to prevent deterioration.
- There should be no gaps between 3½”–9” wide on play equipment where a child’s head or other body parts could get trapped.

*(Source: Southern Early Childhood Association, “Giving Children a Safe Place to Play”)*

**Screen time**

Free play and discretionary time has declined more than 9 hours a week over the last 25 years. A new Nielson Company Report indicates that children ages two–five years old now spend more than 32 hours a week on average in front of a TV screen. Screen technologies can be the television, cell phone, tablet, video games, and even electronic learning devices like LeapPads.

Monitoring the amount of time children spend with screen technologies is as important as monitoring the amount of sugars and fatty foods they eat. Screen time can take children away from very important creative play. It’s virtually impossible for children to experience hands-on play when they are engaged in too much screen time. Children also lose interactions with caring adults when watching screens. Even when adults are watching and using the same screen technology with children less time is spent talking and engaging with the children.

While there are major benefits to screen technologies they should always be used in moderation. Set times for when screen technologies can be used with clear time limits like a schedule, egg timers, or stop watch to help children keep track of time. Screen time is also used differently depending on the age of the child.

**The American Academy of Pediatrics, the American Public Health Association, and the National Resource Center for Health and Safety in Child Care and Early Education recommend the following guidelines for screen time in early care and early education settings:**

- Children younger than two years – no screen time.
- Children two years and older – limited to not more than 30 minutes once a week, and for educational or physical activity use only.
- During meal or snack time – TV, video, or DVD viewing is not allowed.
- Computer use limited to no more than 15-minute increments except for homework and for children who require and consistently use assistive and adaptive computer technology.
- Parents will be informed if screen media are used in the program.
- Any screen media used should be free of advertising and brand placement.

Find out how well you are doing with screen time in your program when you complete the *Let's Move Activity Checklist* in the Appendix.

Help children who may be dependent on screen technologies to engage in hands-on activities and promote creative play. Hands on activities can include playing outside, reading a book, singing, creating art, dancing, or cooking.

Without judging, providers can also encourage families to use less screen time at home. Screen Free Week is a national celebration where everyone can partake in getting away from using screen technologies. More information can be learned at <http://www.screenfree.org/>. Screen Free Week is not the only time to promote limited screen time; providers can create newsletters or spread the word daily about limiting screen time.

Ideas for families to learn to enjoy each other without screen technologies:

- Family game night
- Take a walk together
- Make a meal together
- Have a dance off
- Spend time at the park
- Look through a family album (or put together a family album)
- Play with the children in their rooms (build blocks, play pretend, work puzzles, etc.)
- Read books together.

## Physical Activity Guidelines

**Infants should have access to a safe environment that promotes large muscle activities.**

Motor skill development and a love for moving and active play starts in infancy. Caregivers can nurture initiative and curiosity in infants in a variety of ways.

1. Provide a safe, natural space for children to explore.
2. Allow wide open areas for gross motor movement, and avoid confining spaces such as play-pens, cribs, car seats, swings, and stationary activity centers.
3. Provide a variety of materials and experiences that encourage exploration, movement and hands on discovery (mirrors, rattles, bells, activity boxes, and open containers to fill and empty).
4. Toys and materials should be in a variety of shapes, sizes, textures and weights.

Getting down on the floor to move helps infants:

- Explore the environment
- Develop motor skills
- Build strength and coordination
- Increase body awareness
- Learn to roll over, sit, crawl, stand, and walk
- Learn valuable social skills with their peers

Did you know infants crawl in a variety of ways? Some coordinate their arms first, and then move their legs. Other infants move the limbs on one side of the body and then the other side. Many infants move both arms and legs, coordinating movement of an arm on one side with the leg on the other. Over 25 crawling patterns have been identified. Some infants skip crawling altogether and go from seated scooting to cruising and walking.

**Toddlers learn best through activity**, especially activity that is based on their interests and experiences. Toddlers are also highly motivated by their caregiver's enthusiastic participation, positive feedback, and modeling.

1. Pay attention to toddlers' verbal and nonverbal communication, and be sensitive to the emotions they convey.
2. Toddlers are developing the skills of following directions and learning limitations.
3. Caregivers should frequently provide encouragement, including facial, verbal, and or nonverbal expressions, to motivate toddlers' physical participation.
4. Caregivers may provide physical guidance and support occasionally.
5. Toddlers need 30 minutes of structured physical activity and 60 minutes or more of unstructured physical activity daily.
6. Toddlers should develop movement skills that are building blocks for more complex movement tasks. They need access to safe indoor and outdoor areas that promote gross motor activities.

Toddlers learn by playing and will enjoy playing simple group games with adult assistance. Group games offer children a chance to be social, but expect a little chaos at first. When toddlers play a game they're full of energy, they may not focus for long, and they won't always follow the "rules". Simple circle games, such as "*Hokey-Pokey*", "*Ring Around the Rosie*", and "*Walking, Walking*" work well for toddlers.

**Preschoolers are steady on their feet and learning to hop, skip, jump,** and even somersault. They can follow three part instructions, have the ability to kick and throw a ball, and move forward and backward with ease. They are developing movement skills that are building blocks for more complex movement tasks.

1. Preschoolers are developing balance and coordination skills and often like the challenge of walking a low balance beam.
2. Preschoolers can climb well and run easily. They enjoy obstacle courses that you create for them and they are learning to skip.
3. Preschoolers need access to safe indoor and outdoor areas that promote gross motor activities.
4. Preschoolers need 60 minutes of structured and 60 minutes or more of unstructured physical activity every day. They should not be sedentary for more than 60 minutes at a time except when sleeping.

Preschoolers have a lot of energy, which they use in a more organized way than when they were toddlers. They are also discovering what it means to play with a friend, and gain important social skills, such as sharing and taking turns. They will sometimes play a game of "catch" or "kick the ball" with a friend, and preschoolers are ready for games with simple rules such as "*Duck, Duck, Goose*" and the "*Freeze Game*" to music.

#### **Physical activity helps children:**

- Stay at a healthy weight
- Reduce their risk of feeling stressed or depressed
- Build their strength, flexibility, and endurance
- Enhance their motor skills, social skills, and brain development
- Develop and maintain strong bones
- Sleep better
- Feel confident about themselves and their bodies as they grow

#### **Importance of outdoor time**

Children have a need to connect with nature. Research shows that as children become disconnected from nature, they have a higher risk of:

- Obesity
- Dislike – and even fear – of the outdoors
- Behavioral problems requiring medication

When children play outside, they have limitless opportunities to learn about:

- Science
- Observation skills
- Language and literacy

- Social skills
- Math
- Visual-spatial skills
- Music and movement
- The arts

Children should play outdoors when the conditions do not pose a safety risk, individual child health risk, or significant health risk of frostbite or of heat related illness.

Caregivers must protect children from harm caused by adverse weather, ensuring that children wear appropriate clothing, and appropriate shelter is provided for the weather conditions.

Outdoor play for infants may include riding in a stroller; however, infants should be offered opportunities for gross motor play outdoors, as well.

Weather that poses a significant health risk should include wind chill factor at or below minus 15°F and heat index at or above 90°F, as identified by the National Weather Service (NWS).

Outdoor play requires continuous adult supervision.

**Research shows that regular time in nature:**

- Facilitates better social and physical development.
- Improves fitness, motor-skills, and well-being.
- Supports creativity and imaginative play.
- Inspires collaboration and reduces violence and bullying.
- Reduces stress.
- Creates feelings of empathy for nature – the first step toward developing the next generation of environmental stewards.

(See the Nature Explore website: [www.natureexplore.org](http://www.natureexplore.org) )



## Social Emotional Health

### Fostering Healthy Social-Emotional Development in Infants and Toddlers

(Adapted from the Center for Early Childhood Mental Health Consultation, Georgetown University Center for Child and Human Development)

The quality of each infant and toddler's relationships with familiar adults, especially their parents, sets the foundations for social and emotional health. Social and emotional health is a child's growing ability to:

- Express and manage a variety of feelings
- Develop close relationships with others
- Explore his/her surroundings and learn

### 5 Simple Tips for 5 Everyday Activities

#### Dressing Infants

1. **Talk about what you are doing.** "Mila, Ms. Pima is going to put your shirt on now."
2. **Practice patience.** "David, this shirt is hard for me to get over your head; I am going to try a different way."
3. **Leave extra time.** "It will be time to go home soon, let's get ready Sasha."
4. **Offer positive words.** "Ellen you wiggled your foot into your sock. Way to go!"
5. **Have fun.** "We got your shirt on Dedrea, let's clap your hands!"

#### Dressing Toddlers

1. **Let toddlers help.** "Mika, hold your arms up high, while I pull your shirt over your head!"
2. **Offer choices.** "Josef, do you want to put on the blue or red socks?"
3. **Practice patience.** "Anna, these shoes are tough to get on! Let's take a few deep breaths and try again."
4. **Leave extra time.** "William, we are going outside soon, let's get your jacket and hat."
5. **Offer positive words.** "Nice going, Elena! You got your leg in your pants!"

#### Meal Time with Infants

1. **Hold infants while bottle-feeding.** "I am going to feed you now Brayden. I am going to find a comfortable spot for us."
2. **Look into infant's eyes and connect.** "I see you looking at me Gabe, I love looking at you too."
3. **Talk and sing to infants while feeding.** "You like the orange carrots Calvin, I see that smile!"
4. **Support breastfeeding.** "Mrs. Likins, you can have the rocking chair if you'd like to feed Marketa, or we have an empty office next door."
5. **Notice signs from infants that say, "I am done" or "I need more."** "Kara you are turning your head away, I think you are all done eating."

### Meal Time with Toddlers

1. **Let them help.** “Hey Talia, I bet you could hold your spoon!”
2. **Offer choices.** “Derek, do you want the red cup or the blue cup?”
3. **Eat together.** “I like the carrots; do you like the carrots Jayden?”
4. **Know when a child is hungry.** “Maria, I see you frowning and you are getting frustrated, let’s have a snack that is good for your body.”
5. **Be a role model for healthy eating.** “Dana and Patrick, let’s share this banana.”

### Play Time with Infants

1. **Follow infants’ interests.** Lily, I see you bouncing to the music, let’s dance together!”
2. **Talk about what you see.** “Sal, look at the red and blue balls! Do you want to hold one?”
3. **Sing and read.** “Sri and Nathan, snuggle in and let’s look at this story together.”
4. **Offer encouragement.** “Helena, you almost rolled over, come on big girl, let’s try again!”
5. **Have fun and laugh together.** “I love your giggles, Tasha!”

### Play Time with Toddlers

1. **Join in the play!** “Ashton, I will run with you, let’s go!”
2. **Stay close by.** “Michael, I am right here, I see you playing with trucks.”
3. **Talk about what you see.** “Mia, you are jumping up and down with a big smile! You are excited.”
4. **Show toddlers how to do new things.** “Nicole, you can hold the bowl with this hand and then stir!”
5. **Have fun and laugh together.** “Brady, that’s so silly, you make me laugh!”

### Rest Time with Infants

1. **Create a routine.** “Aden, first we will read stories, and then we’ll get ready for naptime.”
2. **Use routines across care and home settings.** “Your grandmother told us you like it when she sings your favorite song before napping Mya, let’s try that today.”
3. **Leave time for transitioning.** “Mommy’s here to pick you up Hanna, let’s share some of the things you did today.”
4. **Take care of the basics.** “Justin, let’s change your diaper before you rest.”
5. **Take time to refuel.** “Nina, I am going to rock in this chair and do my notes to get ready for playtime later.”

### Rest Time with Toddlers

1. **Create a routine.** “Abia and Fay, in ten minutes we’re going to read two stories and then it’s time for napping.”
2. **Offer toddlers choices.** “Kate, do you want me to rub your back or sing you a song?”
3. **Take care of the basics.** “Jacob, let’s change your diaper before you rest.”
4. **Encourage comfort items.** “Angelique, here is your bear for rest time.”
5. **Learn tips from families.** “Can you tell me more about how you get Harris ready for bed time at home?”

### Diapering Infants

1. **Create a routine.** “Hi Derry, you had a good nap! Let’s check your diaper.”
2. **Know the signs.** “Eli, I see you pulling on your diaper, do you need to be changed?”
3. **Take time to connect.** “Look at that big smile Henry! You make me smile too!”
4. **Offer choices.** “Kia do you want the red ball or the bear to hold while I change you?”
5. **Practice patience.** “I know you don’t like to be changed Jordan, but we need to take good care of you. I am almost done.”

### Diapering and Toileting with Toddlers

1. **Create a routine.** “Li, let’s sit on the potty and then we can wash our hands.”
2. **Know the signs.** “Tamesha, I see you pulling on your diaper, do you need to be changed?”
3. **Offer choices.** “Grace, do you want to talk with Ms. Lena while you are on the potty or be by yourself?”
4. **Follow a child’s lead.** “Marcelo, you are upset right now, let’s try again later.”
5. **Prepare for toileting.** “Angela and Marisa, do you want to read *Once Upon a Potty*?”

## **Promoting Social Emotional Health in Children**

Healthy development from birth focuses on making sure the promotion of mental health is considered when children are young. As adults, one of the greatest things we can do for our children is to make them feel good about themselves and to equip them with a wide repertoire of positive coping strategies. They learn these strategies best when they see them modeled by the important adults in their lives.

### **What parents of young children can do:**

- **Catch your child being good!** Praise your child often for even small accomplishments like playing nicely with brothers or sisters, helping to pick up toys, waiting her turn, or being a good sport.
- **Find ways to play with your child that you both enjoy every day.** Talk with your child, tell stories, sing, and make rhymes together. It is especially important to try and reconnect for a few minutes after separations. Include some type of regular physical activity such as a walk or bike ride around the neighborhood.
- **Seek ways for your child to play with other children** of the same age. Make sure they are watched by a trusted adult.
- **Read with your child every day** as part of a special family routine. Turn off the television before the evening meal, have conversations with your children during the meal, take baths or showers after the meal, and read books with your children in preparation for bedtime. This will help children to settle down and sleep well at the end of the day.

- **Limit screen time** to no more than two hours daily for children 2 and older. The AAP does not recommend any screen time for children younger than 2 years of age. Never put a TV in a child's bedroom. Parents should watch along with older children and try to put the right spin on what their children are seeing. Young children should not be exposed to violence on TV, including on the news. TV should not become a babysitter.
- **Make time for a routine that includes regular family meals** when parents and children can sit and talk about their day together. Play the "high-low" game by taking turns sharing the best and not-so-good parts of the day.
- **Provide regular bedtime routines** to promote healthy sleep. This time of day can become an oasis of calm and togetherness in the day for parents and children.
- **Model behaviors that you want to see in your child.** Parents are their child's first and most important teachers, and what they do can be more important than what they say. Be especially careful of criticizing teachers or other trusted adults in front of the child.
- **Set limits for your child** around safety, regard for others, and household rules and routines that are important to you. Ask others to use these with your child.
- **Be consistent with limits** for your child and encourage all caretaking adults to use the same rules. If you must enforce a rule, do this with supportive understanding. Do not hold a grudge for past mistakes. Encourage learning from mistakes so that they do not happen again.
- **Teach your child to ask for help** and identify who can help her when she needs it. Find opportunities to show her how to ask for help.
- Everyone experiences anger and stress! **Help your child to find acceptable ways of working through feelings of anger and frustration.** It is okay to be mad but never okay to hit or destroy property.
- **Listen to and respect your child.** Remind your child that he or she can always come to you to discuss concerns, fears, and thoughts. Calmly discuss the issues and talk to your child's pediatrician with any concerns you might have as a result.
- **Give choices** when your child is oppositional (eg, Would you like me to carry you upstairs to bed or would you like to walk?) Help your child think of the consequences of her choices when she is demonstrating oppositional behavior.

#### **What early education and child care providers can do:**

- **Greet each child warmly.** Smile, make eye contact, and use a positive tone of voice that says you are happy to see the child.
- **Be friendly and affectionate with each child.** Warmth and affection can be shown through your expression, laughter, voice, and words.
- **Look for each child's strengths.** Make sure that your words and interactions with children are more positive than negative.
- **Show children how to talk to other children and build friendships.** Teach children how to handle problems with others and to ask for help when they need it.
- **Teach children how to follow directions,** including listening, asking questions, and finishing tasks.

- **Reinforce desirable behaviors** by ignoring things that are trivial, providing frequent praise when you see positive behaviors start to emerge, and modeling respectful communication.
- **Provide children with opportunities to make choices** when possible and help them to learn to understand the consequences of their actions.
- **Communicate regularly with parents** and talk to a child's parents early on if you observe behaviors that concern you.
- **Provide mental health services or referrals** when needed for the children, parents, and families. Some child care facilities and schools provide mental health services on site; others can help families connect with community resources and providers of these services.
- **Promote positive morale among staff.** This can help minimize staff turnover and create a more positive mental health environment for all.
- To the extent possible, **keep children with the same caregivers.**

**Resources from the American Academy of Pediatrics: National Children's Mental Health Day**



# Chapter 3: Policies and Procedures





## **Chapter 3: Policies and Procedures**

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## Policies and Procedures

### Establish written policies

It is important to put policies and procedures for your child care program into writing. Written policies help you communicate and clarify the purpose of your program as well as your health, safety, and business practices.

### When developing policies it is important to:

- Be familiar with state child care licensing requirements and city ordinances regarding health and fire safety. (Check with DHS child care licensing and the local health and fire departments).
- Use local resources (child care health consultants, nurses, physicians, and local health agencies) to help develop policies.
- Individualize the policies for your **facility** (your building and location) and your **program** (your mission and goals).
- Write specific and detailed policies. Clearly state expectations and responsibilities.
- Specify how the policies will be enforced.
- Provide copies of the policies for your employees. Ask them to keep you informed about how effective the policies are and if revisions are needed.
- Review the policies with parents upon enrollment. Have them sign two copies, one to keep on file and one for parents to take home. Encourage feedback from parents.
- Review your policies at least once a year. Make changes as needed.

### Content of Policies

Policies should include, but not be limited to, the following information:

- a. Program mission statement or statement of philosophy
- b. A brief program description to include:
  - Days and hours of operation
  - Ages of children accepted
  - A statement of non-discrimination
  - A description of inclusion of children with special health care needs
- c. Holidays (days the program is closed)
- d. Enrollment procedures
- e. Daily sign-in and sign-out procedures, including methods to verify an individual is authorized for pick-up
- f. A statement allowing parent access whenever their child is in care
- g. Payment of fees and deposits
- h. Termination of enrollment and parent notification of termination
- i. Supplies needed and personal belongings

- j. Staffing, including teachers, the use of volunteers, helpers, substitute teachers, and deployment of staff for different activities
- k. Methods of communication between parents and staff; and schedules for conferences
- l. Parent involvement
- m. Supervision of children
- n. Evening and night care plan
- o. Methods of guiding and teaching appropriate behavior (discipline)
- p. Daily health check
- q. Care of children who are ill
- r. Exclusion for children who are ill and alternative care plans
- s. Immunization and health records
- t. Medication administration
- u. Handling urgent medical care
- v. Plan for health promotion and prevention
  - Food and nutrition – including food handling, human milk, feeding and food brought from home, and daily schedule of meals and snacks
  - Physical activity – indoors and outdoors
  - Screen time
  - Daily hygiene
  - Sun safety
- w. Infant safe sleep
- x. Transportation and field trips
- y. Presence and care of animals
- z. Emergency Preparedness: plans and drills for natural and man-made disasters; including an evacuation plan, a shelter-in-place plan, a plan for disruption of utilities, and alternative shelter arrangements when required to leave the area
  - There should be a plan in place to account for all children and staff at the time of an emergency, especially when there is an evacuation or a group is already off site.
  - Assign responsibility to a staff member(s) to bring the class roster or sign-in sheet and practice accounting for all children and adults during every emergency drill.
- aa. Security
- bb. Confidentiality of records
- cc. Smoking, tobacco use, alcohol, prohibited substances
- dd. Weapons
- ee. Maintenance of facility and use of pesticides and possible toxic substances
- ff. Sanitation and hygiene
- gg. Reporting child abuse and neglect
- hh. Review and revision of policies, plans, and procedures

It is a good idea to develop a plan for how you will implement and enforce your policies.

Policies should vary according to the ages and abilities of the children enrolled to accommodate individual or special health care needs.

Adapted from Standard 9.2.1.1 *Caring for Our Children*, 3<sup>rd</sup> Edition

## Privacy and Confidentiality

Child care programs obtain confidential information about enrolled children, their families, and the employees. It is important for administrators and staff to be aware of their ethical and legal responsibility to protect the privacy of individuals and families.

### Confidentiality of records

Programs keep individual files for each enrolled child that may include:

- Enrollment forms with emergency contact information and contact information for those authorized to pick up child
- Family's health insurance information and name of health care provider
- Health screening results and immunization records
- Emergency care consent forms
- Nutritional restrictions
- Progress reports
- Parent conference logs
- Medication logs
- Documentation of behavioral or developmental evaluations, referrals or follow-ups
- Documentation of any injury occurring at the program site

Develop a plan for storing files in locked cabinets that can be accessed by appropriate staff when needed.

### Written consent

Confidentiality must be maintained to protect the children and families in your program, as well as employees. Each program should establish and follow written policies on confidentiality of the records of children and staff. The policies will ensure that materials in the records are not shared with anyone else without the written permission of the parent or guardian.

See sample form *Consent for Release of Information* in the Appendix. Each program should also consider having parents sign a *Permission to Photograph* form. See sample in the Appendix.

### Who needs to know?

1. The director of the program must decide who among the staff needs to know certain confidential information.
2. Caregivers and teachers should not discuss personal information regarding children and their families with any unauthorized person.
3. Confidential information should only be seen by and discussed with staff members who need the information to appropriately care for the child or provide specific services.

### Personal discussions

Caregivers and teachers should not discuss confidential information about families in the presence of others in the program (including children). Remember many children have the ability to repeat your exact words and your "tone of voice". Information should only be shared between staff members when necessary to appropriately care for the children.

### **Technology and privacy**

Your policies should evolve as new technology creates additional challenges to privacy. To maintain confidentiality:

- **Never** release any information about a child, family or employee on the Internet without written permission. This includes photographs, names and contact information, any information or documents from child's or employee's record, and video clips.
- **Never** text information, photos, or videos on cell phones without written permission.
- Consider obtaining written consent upon enrollment for:
  - Posting photographs of children around the program.
  - Putting first name of children on their artwork and on their cubby.
  - Use of a video surveillance camera in the classroom for training purposes.

### **When to disclose information**

1. Staff who prepare and serve food should be fully aware of which children have food allergies and what each affected child is allergic to.
2. Staff members who monitor outdoor play should be aware of any children who are allergic to bee stings, or if any children have chronic conditions which require close monitoring during play.
3. When a child in care is diagnosed with a communicable illness, staff and families of any children who may have been exposed can be notified and instructed to watch for symptoms. This should be done without mentioning the identity of the diagnosed child.
4. A child care program *must* report a known or suspected outbreak of a reportable illness to the public health department and the licensing agency. When this is done, identifying information about the affected child, including name, age, and how to contact the family should be reported. (It would be a good idea to let the family know you are making this contact).
5. Known or suspected child abuse must be reported to DHS Child Welfare. The child's safety and welfare come before the family's right to confidentiality.

### **Available to parents**

Each child's records must be made available to that individual child's parent or guardian upon request.

## Sample Policies and Procedures

*Here is a sample Written Policies and Procedures to guide you as you develop your own.*

**Welcome to the Good Health Child Care Program.** (*We borrowed this name from the title of our Handbook.*) We are happy that you have chosen Good Health Child Care to fulfill your child care needs. This handbook of written policies and procedures explains enrollment, hours of operation and other business policies, as well as detailed plans for the care of the children throughout the day and in all types of situations.

### **Program mission**

We commit to create a stimulating, nurturing environment that builds on children's curiosity and love of learning, and enriches all areas of their development. Our program strives to build partnerships with families and create a community of support. It is our goal to provide a loving atmosphere that emphasizes the healthy and safe development of the whole child.

### **Program description**

The Good Health Child Care Program has a focus on child-centered learning in a safe, healthy, loving and supportive environment. Good Health Child Care provides care:

- Monday through Friday
- 6:30 A.M. – 6:30 P.M.
- For children from 8 weeks of age through 6 years
- For any child without regard to race, color, creed, religion, national origin, gender, or disability; and without regard to a parent or guardian's race, color, creed, religion, sexual orientation or disability.

### **Holidays**

The following is a list of holidays that the Good Health Child Care Program will be closed:

- New Year's Day
- Memorial Day
- Independence Day
- Labor Day
- Thanksgiving and the day after
- Christmas Eve
- Christmas Day
- New Year's Eve we close at 4:00 p.m.

If any of these holidays falls on a weekend, we will be closed either Friday or Monday.

Tuition will remain the same.

### **Process for enrollment**

- Visit our program with your child.
- Review all policies and procedures with the director.
- Fill out and sign all enrollment and permission forms.
- Provide a copy of your child's immunization record, results of any hearing, vision, and developmental screenings, and develop a Special Care Plan with the director if needed.

### **Daily sign-in and sign-out procedures and authorization for pick-up**

- Every child must be signed in and out by an adult each day.
- There is a sign-in pad at the entryway of each classroom where you will write the child's name, the time of arrival, and sign your name.
- Upon pick-up write the time of departure, and sign your name.
- Staff will only allow children to leave with adults who are listed on the enrollment form as "authorized to pick-up", and will ask for identification if they don't know that person.
- Upon enrollment you will receive a security badge that will unlock the front door.
- If you have to make an unexpected change, call us and provide the name of the person who will be picking up your child. Identification will be required when they arrive.

### **Parent access**

As a parent of a child enrolled in the Good Health Child Care Program, you are free to visit at any time, and welcome to join your child for special events and even for breakfast or lunch.

### **Payment**

A deposit of \_\_\_\_ is required for registration and supplies. Payment for each week of care is due Friday of the week before. If payment is not received by Monday morning of the week of care, a late fee of \_\_\_\_ will be charged. An additional fee of \_\_\_\_ will be charged for each day until payment is made.

**Enrollment fee** \_\_\_\_\_ **Due Date** \_\_\_\_\_ **Weekly Tuition** \_\_\_\_\_ **Due Date** \_\_\_\_\_

### **Termination of enrollment**

#### ***Dismissal***

The Good Health Child Care Program reserves the right to dismiss a child for the following reasons (but not limited to):

- Lack of parental cooperation
- Failure to complete and update all required forms
- Routinely late picking up child
- Failure to pay
- Lack of compliance with policies and procedures
- Failure of child to adjust to the program after a reasonable amount of time
- Our inability to meet the child's needs

We will provide two weeks written notice of dismissal for which full tuition is due, whether or not child is in attendance.

The Good Health Child Care Program will not dismiss a child with challenging behaviors without first working with a behavioral or mental health consultant and developing strategies for working with the child. These strategies may include changes to the room arrangement or the daily schedule, or specific methods for guiding the child toward self-regulation. Families will be included in the planning process.

#### ***Withdrawal***

Parents are required to provide two weeks written notice when withdrawing a child from care. The two weeks will be paid in full, regardless of whether or not the child is in attendance.

### **Appropriate clothing and supplies**

Parents must supply the following items:

- A change of clothes
- Diapers and any ointments needed (if child is in diapers)
- Toothbrush – replace twice a year
- **Dress child appropriate for the weather each day – and for playing outdoors!**
- Remember safe, comfortable, supportive shoes for running and playing. No Flipflops!

### **Personal belongings**

We prefer that children do not bring toys from home unless it is something that can be shared with the entire group such as books or music CDs. We are not responsible for any loss or breakage of personal items. All personal items **must** be clearly marked with the child's name.

### **Personnel**

Your child will be assigned a primary caregiver (teacher), however other staff will care for and interact with your child on a regular basis. All personnel have received training and successfully completed fingerprinting and background checks. Occasionally volunteers work in the classroom or assist on special outings, but they will never be left alone with children.

### **Methods of communication**

Good communication is vital!

- Feel free to share any concerns or questions that may arise.
- Allow time at drop-off or pick-up for some brief information sharing with staff.
- You may call or email the Good Health Child Care Program at any time.
- Your child's teacher will schedule a conference with you twice a year to discuss your child's progress and development; however you can request a meeting at any time.
- The Good Health Child Care Program distributes a monthly newsletter to families, and classroom teachers provide weekly classroom updates. Families can decide if they want to receive these electronically or if they want a paper copy.

### **Parent involvement**

Parents are welcomed and encouraged to participate in the early childhood program. Some ways you can be involved include:

- Help your child at home with concepts they are learning (see teacher's classroom update and monthly newsletter).
- Lend or collect objects for units of study.
- Visit the program to talk about and demonstrate your job.
- Volunteer on field trips.
- Visit the program to be a volunteer reader.
- Provide healthy snacks and treats for special events.
- Serve on a Parent / Staff Advisory Board.
- Join your child for breakfast or lunch occasionally.
- Attend parent training events.
- Volunteer for playground repair and clean-up duty.

### **Supervision of children**

Children will be well supervised and a trained staff person will remain with each group of children at all times.

### **Evening and night care**

Currently the Good Health Child Care Program provides care from 6:30 a.m. to 6:30 p.m. If this changes all parents will be notified in advance, as they may want to choose a later shift of care.

### **Methods of guiding and teaching appropriate behavior (discipline)**

We maintain a positive discipline policy, which focuses on prevention, redirection, love, consistency and firmness.

- We stress two main patterns of behavior: respect for other people and respect for property, and we develop our Behavior Guidelines based on these.
- We review the guidelines with the children frequently.
- Please keep in mind that there WILL be disagreements between children. Sometimes they hit, push, throw toys, and even bite.
- Young children are learning how to express their feelings and we try to teach and guide them to do this without hurting others. We help provide words when we tell them to “use their words”. For example: when telling a 2-year-old to “use your words” instead of hitting when he is angry – we may say – “It looks like you were very angry when Sam took your truck. Tell Sam how you feel.”
- At the same time we teach negotiation skills so children learn to work out a plan when they want to play with the same toy (and teach the child who wants the toy next how to request it – “Sam – next time ask Josh if you can please have the truck when he is done.”
- We will try to prevent problems, redirect when appropriate, teach and model appropriate social interactions, and help children learn to manage and communicate their feelings.
- We will discuss inappropriate behavior, encourage making amends when the offense involves another person, and sometimes withdraw privileges based on the principle of “natural consequences”.
- We have a **Comfort Corner** – a designated area in each room that children can choose to go to for some time to reflect and calm down. Children re-join the group when they feel ready. The **Comfort Corner** is equipped with a comfy chair, or a soft rug and pillows, and also has books, soft toys, and squishy and manipulative toys.
- Under NO CIRCUMSTANCES will there be any spanking, physical abuse, verbal abuse, name calling or isolation used. Neither food nor sleep will ever be withheld from children as a means of punishment.

### **Daily Health Check**

As you and your child arrive, a staff member will do a quick Morning Health Check – observing your child for any signs or symptoms of illness, possible fever, skin rashes, swelling or bruises, vomiting or diarrhea, general mood, and complaints of not feeling well, and fill out a **Daily Health Check form**. The health check is completed before parent leaves for the day in case there is an obvious reason that the child is not well enough to stay.

### **Care of children who are ill**

Children who become ill while in care may be sent home if:

- The child's illness is keeping him or her from comfortably taking part in activities,
- The sick child needs more care that the staff can provide without affecting the health and safety of other children, or
- Other children could get sick from being near the sick child.

### **Exclusion for children who are ill and alternative care plans**

A child will be excluded from care at the Good Health Child Care Program when the following symptoms are present:

- Vomiting two or more times
- Diarrhea – two or more watery stools
- Red eyes with white or yellow mucus AND child has not seen health care provider yet
- Sore throat AND fever or swollen glands
- Rash AND fever or mouth sores with drooling
- Fever AND cough, sore throat, rash, vomiting, diarrhea, or pain
- Also any child determined by the local health department to be contributing to the transmission of illness during an outbreak.

Be sure to have an alternate care plan, or be prepared to stay home with your ill child.

### **Immunization and health records**

- A copy of your child's immunization record will be required upon enrollment and you will be responsible for keeping your child's immunizations up-to-date. We will send you a reminder a couple weeks before the next immunizations are due.
- Please provide a copy of any recent health assessments, hearing, vision, dental, and developmental screenings. We will collaborate with you to monitor your child's health and development, and let you know if we have any concerns.
- If your child has a chronic medical condition or special health care need we will work with you and your child's health care provider to develop a *Special Health Care Plan*.

### **Medication administration**

- The Good Health Child Care Program will administer medication to children who have written parental consent and a plan in place that has been made and approved by the Director. Parent must complete and sign the *Medication Administration Form*.
- Whenever possible, the first dose of medication should be given at home to see if the child has any type of reaction.
- Medication must be in original, child-proof container and labeled with child's name.
- All medication containers and dispensers will be stored out of the reach of children and in a locked cabinet, or refrigerator if necessary, and will be returned to parent when completed.
- Prescription medication is administered in accordance with the pharmacy label directions as prescribed by the child's health care provider.
- Non-prescription medication may be administered without approval from the child's health care provider, following the written instructions from the parent, as long as the instructions from the parent do not conflict with the product directions on the container.

- Instructions for the dose, time, method to be used, and duration of administration will be provided in writing on the *Medication Administration Form*.
- A child's health care provider may state that a certain medication may be given for a recurring problem, emergency situation, or chronic condition. The instructions should include the child's name; the name of the medication; the dose of the medication; how often the medication may be given; the conditions for use; and any precautions to follow. **Example:** children who wheeze with vigorous exercise may take one dose of asthma medicine before vigorous active (large muscle) play; a child with a known serious allergic reaction to a specific substance who develops symptoms after exposure to that substance may receive epinephrine from a staff member who has received training in how to use an auto-injection device prescribed for that child (e.g., Epipen®).
- Medication will not be used beyond the date of expiration on the container or beyond any expiration of the instructions provided by the health care provider. Instructions which state that a medication may be administered "as needed" will be renewed by the health care provider at least annually.
- A medication log will be maintained by the program to record instructions for giving the medication, consent obtained from parent, amount, time of administration, and the person who administered each dose of medication. Spills, reactions, and refusal to take medication will be noted on this log.

### **Handling urgent medical care**

- All Good Health Child Care Program personnel maintain their CPR certification and Pediatric First Aid training.
- If a child is injured or becomes seriously ill, the caregiver with that child will assess the child and begin to provide care, and will activate the Emergency Medical Services (EMS) by dialing 911 when immediate medical help is needed.
- The director or person in charge will contact the parents to inform them of the injury or illness and the action taken.
- If EMS decides the child needs to be transported to the hospital, a staff member will accompany the child and remain until the parent assumes responsibility for the child.
- The staff member who is with a child at the time of an injury or serious illness will complete an *incident report form* as soon after the incident as possible.

### **Plan for Health Promotion and Prevention**

The Good Health Child Care Program promotes health through the following policies:

**Food and nutrition**

**Physical activity**

**Screen time**

**Daily hygiene**

**Sun safety**

### **Food and nutrition**

- Meals and snacks will meet the requirements of the **USDA Child and Adult Care Food Program (CACFP)**. We participate in the CACFP and all meals will be provided at no cost to parents. All parents will be required to fill out the *USDA Eligibility Form*.

- Weekly menus will be posted onsite and two weeks of menus will be available to view on our website.
- We are a “***Breastfeeding Friendly***” worksite as designated by the Oklahoma State Department of Health. We encourage breastfeeding and will serve expressed breastmilk and also welcome mothers to breastfeed onsite. We provide a comfortable, quiet breastfeeding area, as well as a place for employees to pump.
- It is our belief that infants should be fed on demand. If parents have another feeding schedule in mind we will discuss it, as long as the infant's needs will be adequately met.
- If your child has allergies and requires a modified diet, we must be notified of this in writing. **We will need to have written instructions from the child’s health care provider describing any foods the child is not permitted to eat.** An appropriate substitution will be made. We may require assistance from parents to provide appropriate substitutions.
- Drinking water will be available to children indoors and outdoors throughout the day.
- Juice will not be served to children younger than one year of age. When juice is served to children one year and older, it will be 100% fruit juice and no more than 4 oz. per day.
- We never force a child to finish what is on his or her plate, but we do encourage each child to try one or two bites. Sometimes they are surprised by what they like!
- Children will be encouraged to serve and feed themselves in a family style environment with serving bowls, plates, and pitchers on the table.
- Children will be seated at the table when eating meals and snacks.
- The adults will act as role models to promote healthy eating behaviors by sitting with the children, eating healthy food, and having a pleasant conversation.

Meal times:

Breakfast: 7:30 – 8:00 A.M.

Mid-morning Snack: 10:00 A.M.

Lunch: 12:00 P.M.

Afternoon Snack: 3:00 P.M.

**Physical activity**

Young children need to be active. We begin teaching healthy living habits by encouraging movement and physical activity.

- Children should be active at least 60 minutes a day.
- Active play will take place indoors and outdoors. Parents must provide weather appropriate clothing.
- Active play will include teacher-led organized play and open-ended free play (where the child decides).

**Screen time**

Screen time includes the use of TVs, DVDs, computers, video games, phones, and other hand-held electronic devices with a screen. Screen time takes children away from hands-on creative play. Children also lose interactions with caring adults and social interactions with each other when watching screens.

In the Good Health Child Care Program screen time is limited to:

- No screen time at all for children under two years of age.
- Programming that is appropriate for children and has no advertisements.
- A 30 minute limit per day, no more than three days per week for children two and older.
- 15 minute increments of computer use except for homework and for children who require assistive and adaptive computer technology.

### **Daily hygiene**

At the Good Health Child Care Program we teach children the importance of good hygiene practices to prevent illness and promote health. Hygiene practices we focus on are:

- Hand washing
- Brushing teeth
- “Cover Your Cough”
- Bathroom etiquette

### **Sun safety**

We will follow our Sun Safety policy to ensure all children and staff members are protected from skin damage caused by the harmful UVB and UVA rays of the sun.

1. Parents will complete and sign the *Parent/Guardian Permission to Apply Sunscreen to Child* and it will remain on file at the program.
2. We will provide a broad spectrum SPF 30 or higher (*paba* and *alcohol* free) sunscreen, and apply to children’s exposed skin 30 minutes before going outdoors.
3. Outdoor play areas will have shade available and activities will be planned for before 10 a.m. and after 3 p.m. as much as possible.
4. We will include learning about sun safety into our curriculum and daily routines.

### **Infant Safe Sleep**

1. Infants will always be put to sleep on their backs.
2. Infants will be placed on a firm mattress, with a fitted crib sheet, in a crib that meets the Consumer Product Safety Commission safety standards.
3. No toys, soft objects, stuffed animals, pillows, bumper pads, blankets, positioning devices or extra bedding will be in the crib or draped over the side of the crib.
4. Sleeping areas will be ventilated and at a temperature that is comfortable for a lightly clothed adult. Infants will not be dressed in more than one extra layer than an adult.
5. If additional warmth is needed, a one-piece blanket sleeper or sleep sack may be used.
6. The infant’s head will remain uncovered for sleep. Bibs and hoods will be removed.
7. Sleeping infants will be actively observed by sight and sound.
8. Infants will not be allowed to sleep on a couch, chair cushion, pillow, or in a car seat, swing or bouncy chair. If an infant falls asleep anyplace other than a crib, the infant will be moved to a crib.
9. An infant who arrives asleep in a car seat will be moved to a crib.
10. Infants may be offered a pacifier for sleep, if provided by the parent.
11. Pacifiers will not be attached to the infant’s clothing, and will not be reinserted if they fall out after the infant is asleep.
12. When able to roll from back to front, the infant will be put to sleep on back and allowed to assume preferred sleep position.

13. In the rare case of a medical condition requiring a sleep position other than on the back, the parent must provide a signed waiver from the infant's health care provider stating the reason for another position.
14. Infants will have supervised "Tummy Time" when they are awake.

### **Transportation and field trips**

The Good Health Child Care Program vehicle provides transportation during the school year to and from our local elementary school, as well as occasional field trips for children two years of age and older. A signed *Permission to Transport Form* must be on file before we will transport your child. Our vehicle is a small bus equipped with child restraint systems.

- The vehicle is licensed and insured for transporting children.
- The vehicle is equipped with a fire extinguisher, first aid kit, and emergency information for all children being transported.
- Drivers of the vehicle are certified in CPR and have completed the OKDHS approved child passenger safety course.
- Parents will receive notification before each field trip.
- Each child will be properly secured in a child passenger restraint system.

### **Presence and care of animals**

- Parents will be notified in advance of any animals at the facility.
- Any pet or animal at our facility, indoors or outdoors, will be in good health and a friendly companion to children.
- Pets will be kept clean and housed in clean living quarters.
- Children and staff will wash hands before and after handling animals.
- Currently the Good Health Child Care Program has two pet gerbils. They are sisters and live together in one large cage. Each classroom (beginning with the two-year-olds), takes turns caring for and feeding the gerbils.

### **Emergency preparedness**

The Good Health Child Care Program has developed and practices emergency plans for:

- Serious injuries or illnesses
- Lost or abducted child
- Poison exposure, including exposure to toxic substances
- Potentially violent situations in the program, including individuals with threatening behaviors
- Natural disasters, including tornado, blizzard, flood, earthquake
- Fires, including wildfires
- Disruption of utilities, including loss of electricity, gas, water

**Shelter-in-place:** An imminent threat of a tornado, or other weather related emergencies will require us to follow our *Shelter-in-place procedures*. If there is a tornado warning in our area we will practice our organized evacuation from the classrooms to the Safe Room that we had designed for the program. All employees are familiar with the procedure and what to take with them. The children practice this evacuation monthly so they remain calm and often help their teacher bring the Shelter-in-place supplies.

**Lock-down:** If there is a potentially violent situation, such as an intruder or a hostage situation that may threaten the safety of the children and personnel, the *Lock-down procedures* will be followed. Personnel are notified through a pre-arranged signal. They keep children in designated safe locations in the building, lock doors when possible, and encourage children to remain calm and quiet.

**Evacuation:** For situations that require everyone leaving the building, such as a fire, the *Evacuation procedures* will be followed. Personnel know at least two ways to evacuate the building with their group of children. The infant room has a crib on wheels that all of the infants are put in and wheeled out. **Everyone will meet on the Northwest corner by the church.**

**Relocation:** Some emergencies require moving to an alternate location, such as a bomb threat, or fast-moving wildfire. The Good Health Child Care Program employees will follow the *Relocation procedures*, which include a plan for transporting everyone, a list of items to bring, a pre-determined location, and a plan for reuniting parents and children.

Our primary relocation site is the Early Childhood Training Center, 200 Main Street, Anywhere, Oklahoma. Our secondary relocation site is the Girl Scout Office, 555 1<sup>st</sup> Street, Somewhere Else, Oklahoma. We will contact all parents when it is safe to pick up your child.

**Some things we will consider when deciding whether to continue caring for children during utility failures:**

- Is there a back-up power supply available?
- Is there an alternative means of cooking food?
- Is a safe heat source available if the weather is cold, or a safe way to ventilate the building if the weather is hot?
- If there is no running water and toilets won't flush we will begin the evacuation procedure for our alternate location. If it is late in the day we will call parents to pick up the children early, rather than relocate everyone.

### **Security**

Entrances are protected from unauthorized visitors by remaining locked from the outside. Upon enrollment parents will receive a security badge that will open the front door when scanned. All other visitors will have to push the buzzer.

**Remember**, if you loan your security badge to a friend or relative to pick up your child and you did not put their name on the enrollment form as "authorized to pick up", they will not be allowed to take your child.

### **Confidentiality of records**

- The Good Health Child Care Program will maintain records of each child, but they will only be accessible to the program director and the child's primary caregiver when needed.
- Each staff person receives training in maintaining confidentiality and signs an annual agreement to maintain confidentiality.
- Each child's record will be made available to that individual child's parent upon request.

- If a parent requests that we share some information from their child's record with another organization, school, or agency, the parent must fill out and sign the ***Consent for Release of Information*** form.

### **Smoking, tobacco use, alcohol, and prohibited substances**

- The indoor and outdoor environment, and vehicles used by the program are designated as non-smoking areas 24 hours a day.
- The use of tobacco, simulated tobacco products, and related items is prohibited on the facility premises and in the vehicles.
- Matches and lighters are inaccessible.
- The use of alcohol or illegal drugs is prohibited on the facility premises.
- Possession of illegal substances or unauthorized potentially toxic substances is prohibited.

### **Weapons**

There are no weapons permitted at the facility. The Good Health Child Care Program has a "No Weapons on Site" policy.

### **Maintenance of facility and use of pesticides and possible toxic substances**

- The Good Health Child Care Program will provide proper maintenance of the building indoors and out, on the playground, and the parking lot.
- All potentially toxic materials, such as pesticides, toxic cleaning materials, and paint and renovation materials will be used according to manufacturer's instructions, and when children are not in care.
- These materials will be stored away from the facility so they will never be accessible to children.

### **Sanitation and hygiene**

We do our best to maintain strict cleanliness and hygiene standards.

- Floors are swept and mopped daily.
- Bathrooms are cleaned at least daily.
- Children use separate cups, plates, bowls and eating utensils that have been thoroughly washed.
- Tables and high chair trays are washed and sanitized before and after each use.
- Children and staff wash hands upon arrival, after going to the bathroom or diaper changing, after coming in from outside and after handling pets, and before and after meals and snacks.
- Infants sleep in separate cribs with clean sheets replaced daily. Crib mattresses are wiped clean and sprayed with sanitizing solution daily.
- Beginning at toddler age, washable cots are used. Each child has a separate cot; with a sheet and a blanket that are washed weekly (unless soiled, then they are washed as often as necessary) and cots are wiped clean and sprayed with sanitizing solution weekly.
- Mouthed toys are washed and sanitized after each use.
- All other toys are cleaned and sanitized as needed (at least weekly).

**Reporting Child Abuse and Neglect**

Any suspected child abuse or neglect will be reported by the personnel of the Good Health Child Care Program. Oklahoma statute (Title 10, Section 7102) defines child abuse as harm or threatened harm to a child’s health, safety, or welfare by a person responsible for the child.

Every person, private citizen or professional, who has reason to believe that a child has been abused, is mandated by law to promptly report suspected abuse to the Oklahoma Department of Human Services (OKDHS), or the Oklahoma Child Abuse Hotline: 1-800-522-3511. Failure to do so is a misdemeanor.

**Review and revision of policies, plans, and procedures**

The policies and procedures are revised and updated as we learn new information and as we receive input from families, so feel free to provide input and to ask questions at any time.

I \_\_\_\_\_ (print name) have gone over these policies with a Healthy Child Care Program staff person and by signing this I agree to follow the policies set forth.

**Parent signature:**

**Date:**

**Chapter 4:**  
**Child Development and**  
**Guiding Children's Behavior**





## **Chapter 4: Child Development & Guiding Children's Behavior**

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## Biting in the Toddler Years

Biting is very common among groups of young children, for all types of reasons, however it causes more upset feelings than any other behavior in child care programs. Because it seems so primitive, we tend to react differently to biting than we do to hitting, grabbing or other aggressive acts. Because it is upsetting and potentially dangerous, it is important for caregivers and parents to address this behavior when it occurs. Though it is normal for infants and toddlers to mouth people and toys, and for many two-year-olds to try biting, most do not continue after the age of three.

Children bite for many different reasons. Take the time to understand why a particular child bites:

- **Watch** to see when and where biting happens, who is involved, what the child experiences, and what happens before and after.
- **Ask** yourself why the child bites others. Is there a pattern to the situations, places, times or other children when biting occurs? What individual or temperamental needs might influence the child's behavior? Have there been changes in the child's health, family or home situation which might affect his/her behavior?
- **Adapt** your environment, schedule or guidance methods to teach gentle and positive ways to handle the child's feelings and needs.

### Most common reasons and solutions for biting

**The experimental biter:** It is not uncommon for an infant or toddler to explore their world, including people, by biting. Infants and toddlers place many items in their mouths to learn more about them. Teach the child that some things can be bitten, like toys and food, and some things cannot be bitten, like people and animals. Another example of the Experimental Biter is the toddler who wants to learn about cause and effect. This child is wondering, 'What will happen when I bite my friend or mommy?' Provide this child with many other opportunities to learn about cause and effect, with toys and activities.

**The teething biter:** Infants and toddlers experience a lot of discomfort when they're teething. A natural response is to apply pressure to their gums by biting on things. It is not unusual for a teething child to bear down on a person's shoulder or breast to relieve some of their teething pain. Provide appropriate items for the child to teeth on, like frozen bagels, teething biscuits, or teething rings.

**The social biter:** Many times an infant or toddler bites when they are trying to interact with another child. These young children have not yet developed the social skills to indicate 'Hi, I want to play with you.' So sometimes they approach a friend with a bite to say hello. Watch young children very closely to assist them in positive interactions with their friends.

**The imitative biter:** Imitation is one of the many ways young children learn. So it is not unusual for a child to observe a friend bite, then try it out for herself. Offer the child many examples of loving, kind behavior. Never bite a child to demonstrate how it feels to be bitten.

**The frustrated biter:** Young children are often confronted with situations that are frustrating, like when a friend takes their toy or when daddy is unable to respond to their needs as quickly as they would like. These toddlers lack the social and emotional skills to cope with their feelings in an acceptable way. They also lack the language skills to communicate their feelings. At these times, it is not unusual for a toddler to attempt to deal with the frustration by biting whoever is nearby. Notice when a child is struggling with frustration and be ready to intervene. It is also important to provide words for the child, to help him learn how to express his feelings, like "That's mine!" or "No! Don't push me!"

**The threatened biter:** When some young children feel a sense of danger they respond by biting as a self-defense. For some children biting is a way to try to gain a sense of control over their lives, especially when they are feeling overwhelmed by their environment or events. Provide the toddler with nurturing support to help him understand that he and his possessions are safe.

**The attention-seeking biter:** Children love attention, especially from adults. When parents give lots of attention for negative behavior, such as biting, children learn that biting is a good way to get attention. Provide lots of positive attention for young children each day. It is also important to minimize the negative attention to behaviors such as biting.

**The power biter:** Toddlers have a strong need for independence and control. Very often the response children get from biting helps to satisfy this need. Provide many opportunities for the toddler to make simple choices throughout the day. This will help the toddler feel the sense of control they need. It is also important to reinforce all the toddler's attempts at positive social behavior each day.

**When a child bites another child:**

- **Intervene immediately** between the child who bit and the bitten child. Stay calm; don't overreact, yell or give a lengthy explanation.
- **Talk briefly to the child who bit.** Use your tone of voice and facial expression to show that biting is not acceptable. Look into the child's eyes and speak calmly but firmly. Say "I do not like it when you bite people", or simply "No biting people." You can point out how the biter's behavior affected the other child. "You hurt him and he's crying."
- **Help the child who was bitten.** Comfort the child and apply first aid. If the skin is broken, wash the wound with warm water and soap. Apply an ice pack or cool cloth to prevent swelling. Tell the parents what happened and recommend that they have the child seen by a physician if the skin is broken or there are any signs of infection (redness and swelling). Encourage the child who was bitten to tell the biter how they feel.
- **Encourage the child who bit to help the other child** by getting the ice pack, etc.
- **Alert the staff** to the incident.
- **Notify the parents of all children involved.** Let them know what happened but do not name or label the child who bit. Reassure them by telling how you handled the incident, and involve the parents in planning how to prevent and handle future biting.
- **Fill out an incident report.**

Source: Oklahoma State Department of Health, Child Guidance Program (2006). *Biting in the Toddler Years*, <http://www.ok.gov/health> .

## Bullying Prevention in Child Care Settings

Early childhood is often the first opportunity for young children to interact with each other. Between the ages of three and five, kids are learning how to get along, cooperate, share, and understand their feelings. Young children may be aggressive and act out when they're angry or don't get what they want, that is not bullying.

There are ways to help children develop skills for getting along with others. All of us who interact with young children can take steps to teach them the skills they need to avoid bullying and ensure a healthy and supportive learning environment. Some important first steps are:

1. **Model how to treat others with kindness and respect.**
2. Model positive ways to make friends and practice taking turns.
3. Set clear rules for behavior. Step in quickly to stop aggressive behavior.
4. Help children understand bullying.

### What is bullying?

Bullying is repeated acts of intentional physical, emotional, or social harm between individuals or groups of unequal power.

**Verbal bullying** is saying or writing mean and hurtful things. Verbal bullying includes:

- Teasing
- Name-calling
- Taunting
- Making negative and demeaning comments
- Threatening to cause harm

**Social bullying**, sometimes referred to as relational bullying, involves hurting someone's reputation or relationships. Social bullying includes:

- Leaving someone out on purpose
- Telling other children not to be friends with someone
- Spreading rumors about someone
- Embarrassing someone in public

**Physical bullying** involves hurting a person's body or possessions. Physical bullying includes:

- Hitting
- Kicking
- Pinching
- Spitting
- Pushing
- Tripping
- Taking or breaking someone's things
- Making mean or rude hand gestures

**Cyberbullying** is bullying that takes place using electronic technology. Electronic technology includes devices and equipment such as cell phones, computers, and tablets. Consider developing policies requiring all phones and electronic devices be left safely in the child's cubby or storage space. Cyberbullying includes:

- Mean text messages or emails
- Rumors sent by email or posted on social media
- Embarrassing pictures, videos, websites or fake profiles

#### **Why cyberbullying is different**

- Cyberbullying can happen 24 hours a day, 7 days a week
- Cyberbullying messages and images can be posted anonymously and distributed quickly to a wide audience
- Deleting inappropriate or harassing messages, texts, and pictures is extremely difficult after they have been posted or sent
- Kids who are cyberbullied are often bullied in person as well

#### **Warning signs of a bully victim**

- Withdraws socially, becomes isolated, feelings of rejections
- Complains of feeling sick often
- Does not want to go to school/child care
- Brings home damaged belongings or reports them "lost"
- Physical evidence: bruises, scratches

#### **Warning signs of a child who bullies**

- Picks fights with others
- Gets satisfaction from others fears, discomforts or pain of others
- Displays uncontrolled anger
- History of violent or aggressive behaviors
- Have friends who bully

**Kids who know what bullying is can identify it.** They can talk about bullying if it happens to them or others. Kids need to know ways to safely stand up to bullying and how to get help.

- Encourage children to speak to a trusted adult if they are bullied or see others being bullied.
- Encourage children to report bullying if it happens.
- Talk about how to stand up to kids who bully. Give tips, like using humor and saying "stop" directly and confidently. Talk about what to do if those actions don't work, like walking away.
- Talk about strategies for staying safe, such as staying near adults or groups of other kids.
- Urge them to help kids who are bullied by showing kindness or getting help.
- Teach the difference between tattling and reporting.
- Tattling is telling on another person to gain attention or power, not concerned with the well-being of the other person.
- Reporting is telling a trusted adult to help protect the person from emotional or physical harm, concerned with helping another person.

### **Sample activity to do with children**

Role-play different scenes to help children see the difference between telling to get someone IN trouble or, telling to help someone OUT of trouble.

Examples of *tattling*: "Sam took Lily's book." "Sara won't play fair." "Jessica keeps talking to me."

Examples of *reporting*: "Chris is beating up Adam on the playground." "Melissa keeps calling Natalie mean names in the rest room." "Sam was making fun of the way Bill runs and will not let him play."

#### **Ask the child:**

"Are you telling me (state the behavior) to be harmful (tattling) or helpful (reporting)?"

"Are you trying to get someone in trouble?" (tattling)

"Are you helping a friend who is hurt?" (reporting)

### **Tips for parents and teachers to prevent bullying on the playground**

- Establish a "go to person" for bullying incidents, such as a teacher or playground supervisor.
- Avoid bullying hot spots (less well supervised areas on the playground).
- Ensure enough teachers are supervising outdoor play.
- Have structured and supervised activities during outdoor play.
- Inform personnel if a child is being bullied.

### **Have a simple plan to address bullying**

Make sure all staff know what problem signs to look for, such as:

- A student who is consistently off by themselves.
- A group of kids restricting other children from playing in a certain area.
- Children pointing and laughing at someone.
- A child who seems withdrawn and depressed but is reluctant to give you a reason.

### **On-the-spot interventions for bullying from the Olweus Bullying Prevention Program**

1. Stop the bullying.
2. Support the student who has been bullied.
3. Address the student(s) who bullied by naming the bullying behavior.  
Bystanders are crucial to the school environment. Provide them with information on how to act in the future.
4. Empower bystanders to stand up for others and be a friend!
5. Impose immediate and appropriate consequences for the student(s) who bullied.
6. Take steps to make sure the student who was bullied will be protected from future bullying.

### **Avoid these common mistakes**

- Don't ignore it. Don't think kids can work it out without adult help.
- Don't immediately try to sort out the facts.
- Don't force other kids to say publicly what they saw.
- Don't question the children involved in front of other kids.

- Don't talk to the kids involved together, only separately.
- Don't make the kids involved apologize or patch up relations on the spot.

### **Importance of not labeling kids**

When referring to a bullying situation, it is easy to call the children who bully others "bullies" and those who are targeted "victims," but this may have unintended consequences. When children are labeled as "bullies" or "victims" it may:

- Send the message that the child's behavior cannot change.
- Fail to recognize the multiple roles children might play in different bullying situations.
- Disregard other factors contributing to the behavior such as peer influence, school climate or problems at home.

Instead of labeling the children involved, focus on the behavior. For instance:

- Instead of calling a child a "bully," refer to them as *"the child who bullied."*
- Instead of calling a child a "victim," refer to them as *"the child who was bullied."*
- Instead of calling a child a "bully/victim," refer to them as *"the child who was both bullied and bullied others."*

### **Resources for providers, parents, caregivers and community**

**FREE** KnowBullying App from SAMHSA, mobile app for parents that includes conversation starters, tips, warning signs, reminders, and section for educators.

<http://store.samhsa.gov/apps/bullying/>

**Watch Sesame Street's** "Good Birds Club" episode where Big Bird is bullied by another bird in the neighborhood. The show empowers children by providing strategies for dealing with bullying, and encourages them to seek the help of a trusted adult.

<http://www.sesamestreet.org/parents/topicsandactivities/topics/bullying>

15+ Make Time to Listen, Take Time to Talk...About Bullying: Conversation Starter Cards (Substance Abuse and Mental Health Services Administration (SAMHSA) Publication- FREE)

<http://store.samhsa.gov/product/15-Make-Time-To-Listen-Take-Time-To-Talk-About-Bullying-Conversation-Starter-Cards/SMA08-4321>

Preventing Bullying in Early Childhood: Eyes on Bullying in Early Childhood book.

<http://preventingbullying.promoteprevent.org/preventing-bullying-in-early-childhood>

<http://www.stopbullying.gov/index.html>

Oklahoma State Department of Education: Bullying Prevention Resources

<http://ok.gov/sde/bullying-prevention>

For staff trainings or resources contact: Oklahoma State Department of Health, Child and Adolescent Health Division, 405-271-4471.

## **Books about Bullying Behavior**

### **Pre-school**

*Andrew's Angry Words*, D. Lachner  
*Big Mean Mike*, M. Knudsen  
*Hands are Not for Hitting*, M. Agassi  
*How to Lose All Your Friends*, N. Carlson  
*I'm Mad*, E. Crary  
*The Way I Feel*, J. Cain  
*We Can Get Along: A Child's Book of Choices*, L. Payne

### **Beginning Elementary (Grades K –3)**

*Ballerinas Don't Wear Glasses*, Ainslie Manson  
*Hey, Pipsqueak!* Kate McMullan  
*Lucy and the Bully*, Claire Alexander  
*Stand Tall, Molly Lou Melon*, Patty Lovell  
*The Berenstain Bears and Too Much Teasing*, Stan and Jan Berenstain.  
*The Ugly Duckling*, Hans Christian Andersen

### **Middle Elementary (Grades 3 – 6)**

*Don't Be a Bully: Be a Buddy*, Flora Cousins  
*How To Handle Bullies, Teasers and Other Meanies*, Kate Cohen-Posey  
*Marvin Redpost: Why Pick on Me?*, Louis Sachar  
*Stand In My Shoes, Learning About Empathy* – Bob Sornson  
*Telling Isn't Tattling*, Kathryn M. Hammerseng  
*Thank You Mr. Falker*, Patricia Polacco (based on a true story)  
*The Juice Box Bully, Empowering Kids To Stand Up For Others*, Bob Sornson

### **Middle School**

*Stick up for Yourself*, G. Kaufman, L. Raphael, P. Espeland  
*Stop Picking on Me: A First Look at Bullying*, Pat Thomas  
*The Skin I'm In*, Sharon Flake  
*The Computer's Nerd*, W. Royce Adams



## Child Development

**It is important to know and understand children's typical growth and development to be able to create learning experiences and design quality environments that are safe and encourage children's mastery of new skills. Norms have been established for children's growth and development to serve as a reference, but it's important to remember that every child is a unique individual.**

**By continually observing children's play and interactions we learn about each child's interests, abilities, and developmental progress, we see what areas to focus on when designing the environment and planning activities.**

### Important Milestones

Adapted from the Center for Disease Control's "*Learn the Signs. Act Early.*" campaign. Developmental milestones are things *most* children can do by a certain age.

#### What most babies do at this age: 2 Months

##### Social and Emotional

Begins to smile at people

Can briefly calm himself (may bring hands to mouth and suck on hand)

Tries to look at parent

##### Language/Communication

Coos, makes gurgling sounds

Turns head toward sounds

##### Cognitive (learning, thinking, problem-solving)

Pays attention to faces

Begins to follow things with eyes and recognize people at a distance

Begins to act bored (cries, fussy) if activity doesn't change

##### Movement/Physical Development

Can hold head up and begins to push up when lying on tummy

Makes smoother movements with arms and legs

#### **Act early by talking to your child's doctor if your child:**

- Doesn't respond to loud sounds
- Doesn't watch things as they move
- Doesn't smile at people
- Doesn't bring hands to mouth
- Can't hold head up when pushing up when on tummy

### **What most babies do at this age: 4 Months**

#### Social and Emotional

- Smiles spontaneously, especially at people
- Likes to play with people and might cry when playing stops
- Copies some movements and facial expressions, like smiling or frowning

#### Language/Communication

- Begins to babble
- Babbles with expression and copies sounds he hears
- Cries in different ways to show hunger, pain, or being tired

#### Cognitive (learning, thinking, problem-solving)

- Lets you know if she is happy or sad
- Responds to affection
- Reaches for toy with one hand
- Uses hands and eyes together, such as seeing a toy and reaching for it
- Follows moving things with eyes from side to side
- Watches faces closely
- Recognizes familiar people and things at a distance

#### Movement/Physical Development

- Holds head steady, unsupported
- Pushes down on legs when feet are on a hard surface
- May be able to roll over from tummy to back
- Can hold a toy and shake it and swing at dangling toys
- Brings hands to mouth
- When lying on stomach, pushes up to elbows

#### **Act early by talking to your child's doctor if your child:**

- Doesn't watch things as they move
- Doesn't smile at people
- Can't hold head steady
- Doesn't coo or make sounds
- Doesn't bring things to mouth
- Doesn't push down with legs when feet are placed on a hard surface
- Has trouble moving one or both eyes in all directions

### **What most babies do at this age: 6 Months**

#### Social and Emotional

- Knows familiar faces and begins to know if someone is a stranger
- Likes to play with others, especially parents
- Responds to other people's emotions and often seems happy
- Likes to look at self in a mirror

Language/Communication

- Responds to sounds by making sounds
- Strings vowels together when babbling (“ah,” “eh,” “oh”) and likes taking turns with parent while making sounds
- Responds to own name
- Makes sounds to show joy and displeasure
- Begins to say consonant sounds (jabbering with “m,” “b”)

Cognitive (learning, thinking, problem-solving)

- Looks around at things nearby
- Brings things to mouth
- Shows curiosity about things and tries to get things that are out of reach
- Begins to pass things from one hand to the other

Movement/Physical Development

- Rolls over in both directions (front to back, back to front)
- Begins to sit without support
- When standing, supports weight on legs and might bounce
- Rocks back and forth, sometimes crawling backward before moving forward

**Act early by talking to your child's doctor if your child:**

- Doesn't try to get things that are in reach
- Shows no affection for caregivers
- Doesn't respond to sounds around him
- Has difficulty getting things to mouth
- Doesn't make vowel sounds (“ah”, “eh”, “oh”)
- Doesn't roll over in either direction
- Doesn't laugh or make squealing sounds
- Seems very stiff, with tight muscles
- Seems very floppy, like a rag doll

**What most babies do at this age: 9 Months**

Social and Emotional

- May be afraid of strangers
- May be clingy with familiar adults
- Has favorite toys

Language/Communication

- Understands “no”
- Makes a lot of different sounds like “mamamama” and “bababababa”
- Copies sounds and gestures of others
- Uses fingers to point at things

Cognitive (learning, thinking, problem-solving)

- Watches the path of something as it falls
- Looks for things he sees you hide

- Plays peek-a-boo
- Puts things in her mouth
- Moves things smoothly from one hand to the other
- Picks up things like cereal o's between thumb and index finger

#### Movement/Physical Development

- Stands, holding on
- Can get into sitting position
- Sits without support
- Pulls to stand
- Crawls

#### **Act early by talking to your child's doctor if your child:**

- Doesn't bear weight on legs with support
- Doesn't sit with help
- Doesn't babble ("mama", "baba", "dada")
- Doesn't play any games involving back-and-forth play
- Doesn't respond to own name
- Doesn't seem to recognize familiar people
- Doesn't look where you point
- Doesn't transfer toys from one hand to the other

#### **What most toddlers do at this age: 12 Months**

##### Social and Emotional

- Is shy or nervous with strangers
- Cries when mom or dad leaves
- Has favorite things and people
- Shows fear in some situations
- Hands you a book when he wants to hear a story
- Repeats sounds or actions to get attention
- Puts out arm or leg to help with dressing
- Plays games such as "peek-a-boo" and "pat-a-cake"

##### Language/Communication

- Responds to simple spoken requests
- Uses simple gestures, like shaking head "no" or waving "bye-bye"
- Makes sounds with changes in tone (sounds more like speech)
- Says "mama" and "dada" and exclamations like "uh-oh!"
- Tries to say words you say

##### Cognitive (learning, thinking, problem-solving)

- Explores things in different ways, like shaking, banging, throwing
- Finds hidden things easily
- Looks at the right picture or thing when it's named
- Copies gestures
- Starts to use things correctly; for example, drinks from a cup, brushes hair

Bangs two things together

- Puts things in a container, takes things out of a container
- Lets things go without help
- Pokes with index (pointer) finger
- Follows simple directions like "pick up the toy"

#### Movement/Physical Development

- Gets to a sitting position without help
- Pulls up to stand, walks holding on to furniture ("cruising")
- May take a few steps without holding on
- May stand alone

#### **Act early by talking to your child's doctor if your child:**

- Doesn't crawl
- Can't stand when supported
- Doesn't search for things that she sees you hide
- Doesn't say single words like "mama" or "dada"
- Doesn't learn gestures like waving or shaking head
- Doesn't point to things
- Loses skills he once had

#### **What most toddlers do at this age: 18 Months**

##### Social and Emotional

- Likes to hand things to others as play
- May have temper tantrums
- May be afraid of strangers
- Shows affection to familiar people
- Plays simple pretend, such as feeding a doll
- May cling to caregivers in new situations
- Points to show others something interesting
- Explores alone but with parent close by

##### Language/Communication

- Says several single words
- Says and shakes head "no"
- Points to show someone what he wants

##### Cognitive (learning, thinking, problem-solving)

- Knows what ordinary things are for; for example, telephone, brush, spoon
- Points to get the attention of others
- Shows interest in a doll or stuffed animal by pretending to feed
- Points to one body part
- Scribbles on his own
- Can follow 1-step verbal commands without any gestures; for example, sits when you say "sit down"

Movement/Physical Development

- Walks alone
- May walk up steps and run
- Pulls toys while walking
- Can help undress herself
- Drinks from a cup
- Eats with a spoon

**Act early by talking to your child's doctor if your child:**

- Doesn't point to show things to others
- Can't walk
- Doesn't know what familiar things are for
- Doesn't copy others
- Doesn't gain new words
- Doesn't have at least 6 words
- Doesn't notice or mind when a caregiver leaves or returns
- Loses skills he once had

**What most children do at this age: 2 Years**

Social and Emotional

- Copies others, especially adults and older children
- Gets excited when with other children
- Shows more and more independence
- Shows defiant behavior (doing what he has been told not to)
- Plays mainly beside other children, but is beginning to include other children

Language/Communication

- Points to things or pictures when they are named
- Knows names of familiar people and body parts
- Says sentences with 2 to 4 words
- Follows simple instructions
- Repeats words overheard in conversation
- Points to things in a book

Cognitive (learning, thinking, problem-solving)

- Finds things even when hidden under two or three covers
- Begins to sort shapes and colors
- Completes sentences and rhymes in familiar books
- Plays simple make-believe games
- Builds towers of 4 or more blocks
- Might use one hand more than the other
- Follows two-step instructions such as "Pick up your shoes and put them in the closet."
- Names items in a picture book such as a cat, bird, or dog

### Movement/Physical Development

- Stands on tiptoe
- Kicks a ball
- Begins to run
- Climbs onto and down from furniture without help
- Walks up and down stairs holding on
- Throws ball overhand
- Makes or copies straight lines and circles

### **Act early by talking to your child's doctor if your child:**

- Doesn't use 2-word phrases (for example, "drink milk")
- Doesn't know what to do with common things, like a brush, phone, fork, spoon
- Doesn't copy actions and words
- Doesn't follow simple instructions
- Doesn't walk steadily
- Loses skills she once had

### **What most children do at this age: 3 Years**

#### Social and Emotional

- Copies adults and friends
- Shows affection for friends without prompting
- Takes turns in games
- Shows concern for crying friend
- Understands the idea of "mine" and "his" or "hers"
- Shows a wide range of emotions
- Separates easily from mom and dad
- May get upset with major changes in routine
- Dresses and undresses self

#### Language/Communication

- Follows instructions with 2 or 3 steps
- Can name most familiar things
- Understands words like "in," "on," and "under"
- Says first name, age, and sex
- Names a friend
- Says words like "I," "me," "we," and "you" and some plurals (cars, dogs, cats)
- Talks well enough for strangers to understand most of the time
- Carries on a conversation using 2 to 3 sentences

#### Cognitive (learning, thinking, problem-solving)

- Can work toys with buttons, levers, and moving parts
- Plays make-believe with dolls, animals, and people
- Does puzzles with 3 or 4 pieces
- Understands what "two" means
- Copies a circle with pencil or crayon
- Turns book pages one at a time

- Builds towers of more than 6 blocks
- Screws and unscrews jar lids or turns door handle

#### Movement/Physical Development

- Climbs well
- Runs easily
- Pedals a tricycle (3-wheel bike)
- Walks up and down stairs, one foot on each step

#### **Act early by talking to your child's doctor if your child:**

- Falls down a lot or has trouble with stairs
- Drools or has very unclear speech
- Can't work simple toys (such as peg boards, simple puzzles, turning handle)
- Doesn't speak in sentences
- Doesn't understand simple instructions
- Doesn't play pretend or make-believe
- Doesn't want to play with other children or with toys
- Doesn't make eye contact
- Loses skills he once had

#### **What most children do at this age: 4 years**

##### Social and Emotional

- Enjoys doing new things
- Plays "Mom" and "Dad"
- Is more and more creative with "make-believe"
- Would rather play with other children than alone
- Cooperates with other children
- Often can't tell what's real and what's make-believe
- Talks about likes and interests

##### Language/Communication

- Knows some basic rules of grammar, such as correctly using "he" and "she"
- Sings a song or says a poem from memory such as the "Itsy Bitsy Spider"
- Tells stories
- Can say first and last name

##### Cognitive (learning, thinking, problem-solving)

- Names some colors and some numbers
- Understands the idea of counting
- Starts to understand time
- Remembers parts of a story and tells you what is going to happen next
- Understands the idea of "same" and "different"
- Draws a person with 2 to 4 body parts
- Uses scissors
- Starts to copy some capital letters
- Plays board or card games

Movement/Physical Development

- Hops and stands on one foot up to 2 seconds
- Catches a bounced ball most of the time
- Pours, cuts with supervision, and mashes own food

**Act early by talking to your child's doctor if your child:**

- Can't jump in place
- Has trouble scribbling
- Shows no interest in interactive games or make-believe
- Ignores other children or doesn't respond to people outside the family
- Resists dressing, sleeping, and using the toilet
- Can't retell a favorite story
- Doesn't follow 3-part commands
- Doesn't understand "same" and "different"
- Doesn't use "me" and "you" correctly
- Speaks unclearly
- Loses skills he once had

**What most children do at this age: 5 years**

Social and Emotional

- Wants to please friends
- Wants to be like friends
- More likely to agree with rules
- Likes to sing, dance, and act
- Shows concern and sympathy for others
- Is aware of gender
- Can tell what is real and what is make-believe
- Shows more independence (for example, may visit a next-door neighbor by himself [adult supervision is still needed])
- Is sometimes demanding and sometimes very cooperative

Language/Communication

- Speaks very clearly
- Tells a simple story using full sentences
- Uses future tense; for example, "Grandma will be here."
- Says name and address

Cognitive (learning, thinking, problem-solving)

- Counts 10 or more things
- Can draw a person with at least 6 body parts
- Can print some letters or numbers
- Copies a triangle and other geometric shapes
- Knows about things used every day, like money and food

### Movement/Physical Development

- Stands on one foot for 10 seconds or longer
- Hops; may be able to skip
- Can do a somersault
- Uses a fork and spoon and sometimes a table knife
- Can use the toilet independently
- Swings and climbs

### **Act early by talking to your child's doctor if your child:**

- Doesn't show a wide range of emotions
- Shows extreme behavior (unusually fearful, aggressive, shy or sad)
- Unusually withdrawn and not active
- Is easily distracted, has trouble focusing on one activity for more than 5 minutes
- Doesn't respond to people, or responds only superficially
- Can't tell what is real and what is make-believe
- Doesn't play a variety of games and activities
- Can't give first and last name
- Doesn't use plurals or past tense properly
- Doesn't talk about daily activities or experiences
- Doesn't draw pictures
- Can't brush teeth, wash and dry hands, or get undressed without help
- Loses skills he once had

### **Middle Childhood (6-8 years of age)**

Middle childhood brings many changes in a child's life. By this time, children can dress themselves, catch a ball more easily using only their hands, and tie their shoes. Having independence from family becomes more important now. Events such as starting school bring children this age into regular contact with the larger world. Friendships become more and more important. Physical, social, and mental skills develop quickly at this time. This is a critical time for children to develop confidence in all areas of life, such as through friends, schoolwork, and sports.

### Emotional/Social Changes

- Shows more independence from parents and family.
- Starts to think about the future.
- Understands more about his or her place in the world.
- Pays more attention to friendships and teamwork.
- Wants to be liked and accepted by friends.

### Thinking and Learning

- Shows rapid development of mental skills.
- Learns better ways to describe experiences and talk about thoughts and feelings.
- Has less focus on one's self and more concern for others.

**Some things you, as a caregiver, can do to help the child during this time:**

- Show affection for the child. Recognize her accomplishments.
- Help the child develop a sense of responsibility—ask him to help with tasks.
- Talk with the child about school, friends, and things she looks forward to in the future.
- Talk with the child about respecting others. Encourage him to help people in need.
- Help the child set her own achievable goals—she'll learn to take pride in herself and rely less on approval or reward from others.
- Help the child learn patience by letting others go first or by finishing a task before going out to play. Encourage him to think about possible consequences before acting.
- Make clear rules and stick to them. Be clear about what behavior is okay and what is not okay.
- Continue reading to him. As he learns to read, take turns reading to each other.
- Use discipline to guide and protect, rather than punishment to make him feel bad about himself. Follow up any discussion about what not to do with a discussion of what to do instead.
- Praise her for good behavior. It's best to focus praise more on what she does ("you worked hard to figure this out") than on traits she can't change ("you are smart").
- Support the child in taking on new challenges. Encourage her to solve problems, such as a disagreement with another child, on her own.
- Encourage the child to join school and community groups, such as a team sports, or to take advantage of volunteer opportunities.

**Middle Childhood (9-11 years of age)**

Your child's growing independence from the family and interest in friends might be obvious by now. Healthy friendships are very important to your child's development, but peer pressure can become strong during this time. Children who feel good about themselves are more able to resist negative peer pressure and make better choices for themselves. This is an important time for children to gain a sense of responsibility along with their growing independence. Also, physical changes of puberty might be showing by now, especially for girls. Another big change children need to prepare for during this time is starting middle or junior high school.

Emotional/Social Changes

- Starts to form stronger, more complex friendships and peer relationships. It becomes more emotionally important to have friends, especially of the same sex.
- Experiences more peer pressure.
- Becomes more aware of his or her body as puberty approaches. Body image and eating problems sometimes start around this age.

Thinking and Learning

- Faces more academic challenges at school.
- Becomes more independent from the family.
- Begins to see the point of view of others more clearly.
- Has an increased attention span.

**Some things you, as a caregiver, can do to help the child during this time:**

- Spend time with your child. Talk with her about her friends, her accomplishments, and what challenges she will face.
- Encourage your child to join school and community groups, such as a sports team, or to be a volunteer for a charity.
- Help the child develop his own sense of right and wrong. Talk with him about risky things friends might pressure him to do, like smoking or dangerous physical dares.
- Help your child develop a sense of responsibility—involve your child in household tasks like cleaning and cooking. Talk with your child about saving and spending money wisely.
- Talk with your child about respecting others. Encourage her to help people in need. Talk with her about what to do when others are not kind or are disrespectful.
- Help your child set his own goals. Encourage him to think about skills and abilities he would like to have and about how to develop them.
- Make clear rules and stick to them. Talk with your child about what you expect from her (behavior) when no adults are present. If you provide reasons for rules, it will help her to know what to do in most situations.
- Use discipline to guide and protect your child, instead of punishment to make him feel badly about himself.
- When using praise, help your child think about her own accomplishments. Saying "you must be proud of yourself" rather than simply "I'm proud of you" can encourage your child to make good choices when nobody is around to praise her.
- Talk with your child about the normal physical and emotional changes of puberty.
- Encourage your child to read every day. Talk with him about his homework.

## **Children and Stress**

Stress is a part of everyday life and can affect anyone who feels overwhelmed — even children. Prolonged, unreleased stress or sudden, very intense stress can cause physical and emotional illness. Children learn how to cope with stress early in life by watching those around them deal with the pressures of life. We need to identify sources of stress early in children's lives and teach and model healthy coping techniques for children of all ages.

### **Sources of children's stress**

Family stressors can include:

- Birth of a sibling
- Moving
- Death of a family member
- Death of a family pet
- Poverty
- Neglect or abuse
- Divorce of parents, or separation from a parent
- Domestic violence

Stressors outside the family can include:

- Chronic illness or other health issues
- School
- Poor quality child care
- Natural disasters
- War
- Violence

Children's stress may be intensified by more than just what's happening in their own lives. If they hear their parents talking about problems at work, worrying about a relative's illness, or arguing about money they will pick up on these anxieties and start to worry themselves. Parents should be aware of how they discuss such issues when their kids are near.

World news can cause stress. Children who see disturbing images on TV or hear talk of natural disasters, war, and terrorism may worry about their own safety and that of the people they love. It's important to talk to kids honestly about what they see and hear, and monitor what they watch on TV so that you can help them understand what's going on.

Some things that aren't a big deal to adults can cause significant stress for children. If this happens, let your kids know that you understand they're stressed and don't dismiss their feelings as inappropriate.

### **Signs and symptoms of stress**

- Sleep disturbances
- Physical complaints (stomach aches, headaches)
- Change in appetite
- Change in speech patterns and abilities

- Difficulty making choices
- Problems with attention or concentration
- Withdrawal
- Aggressive behavior

Younger children may pick up new bad habits like thumb sucking, hair twirling, or nose picking; older kids may begin to lie, bully, or defy authority. A child who is stressed may also have nightmares, difficulty being away from parents and caregivers, overreactions to minor problems, and drastic changes in academic performance.

### **Reducing stress**

- Proper rest and good nutrition can boost coping skills.
- Provide and maintain consistent routines so the child knows what to expect.
- Provide daily opportunities for vigorous exercise. This is a natural stress reducer.
- Build relaxation periods into the routine. Everyone can practice stretching, tensing and relaxing muscle groups, and deep breathing.
- Allow for a natural expression of emotions through talk, play, and art.
- Make time for listening, and providing understanding and caring communication.
- Let children know that it's OK to feel angry, scared, lonely, or anxious and that other people share those feelings.
- Discuss appropriate actions and behaviors people can use when they're afraid, angry, or overwhelmed.
- Teach alternative strategies for destructive or inappropriate behavior.
- Provide children's books as a way to explore and express emotions. Books can help young kids identify with characters in stressful situations and learn how they cope.
  - Alexander and the Terrible, Horrible, No Good, Very Bad Day*, by Judith Viorst
  - Tear Soup*, by Pat Schweibert, Chuck DeKlyen, and Taylor Bills
  - Alex and the Rabbit*, by Monica Dumont
  - Billy Monster's Daymare*, by Alan Durant
  - The Great Big Book of Feelings*, by Mary Hoffman
- Make time to be silly. Sometimes children feel better when you spend time with them on fun (and silly) activities.

Stress is inevitable, but we have the ability to adapt and learn something positive from these situations.

Further details of children coping with divorce, emergencies, grief and loss, and separation are included below.

## Children and Divorce

Divorce can be a very scary time for children. They will experience a number of changes in their lives. All of these changes can effect a child's physical and emotional growth. As a caregiver, there are ways to help children cope during this time.

### Important Things to Know

- **Divorce is an adult problem.** The child(ren) did not cause the parents to divorce.
- **Children need both parents.** Children benefit when both parents play major roles in their lives, except in cases where one parent is abusive or unable to provide proper care and supervision.
- **Consistent routines are developmentally important** for all children, but especially young children. Urge parents to try to keep a fairly consistent routine for their children.

### Children's Needs, Issues, and Ways to Help

#### ***Needs for children 0-18 months:***

- consistency of caregivers, environment, and routine
- emotional connection with caregiver
- nurturing and love

#### ***What to watch for:***

- sleeping changes
- eating changes
- clingy behavior/difficulty separating

#### ***What you can do to help:***

- maintain consistency in people and routines
- change routines very gradually
- avoid angry expressions and emotional outbursts in front of the baby
- don't fight in front of the baby

#### ***Needs for children 18 months - 3 years:***

- consistency of caregivers, environment, and routine
- fear absent parent has disappeared
- nurturing and love
- security (who will take care of me?)

#### ***What to watch for:***

- increased crying
- trouble getting to sleep/nightmares
- demanding to be fed by parent instead of feeding self
- changes in toilet habits
- increased anger (temper tantrums, hitting, etc.)
- clinging to adults or security objects

***What you can do to help:***

- give love and affection
- provide verbal assurances (Mom and Dad both say, "I love you")
- maintain consistency of people and routines
- reassure the child that he or she will be cared for
- provide clear and concrete explanation of changes
- provide opportunities for the child to express feelings through words or play
- avoid angry expressions or emotional outbursts in front of the child
- don't fight in front of the child

***Needs for children ages 3-5 years:***

- fear of being abandoned/rejected
- doubts he/she is loveable (did Mommy/Daddy leave because I'm not good enough?)
- blame themselves for what happened (did I cause this because I was bad?)

***What to watch for:***

- regression in sleeping/eating/talking
- clingy behavior/difficulty with separation
- increased anger
- increased passivity (over-compliance)

***What you can do to help:***

- give love and affection
- provide verbal assurances (Mom and Dad both say, "I love you")
- maintain consistency of people and routines
- reassure the child that he or she will be cared for
- provide clear and concrete explanation of changes ("Mom and Dad won't live together anymore, but we will always be your Mom and Dad together and always love you.")
- provide opportunities for the child to express feelings through words or play
- avoid angry expressions or emotional outbursts in front of the child
- don't fight in front of the child
- NEVER criticize the other parent to the child
- NEVER put the child "in the middle"

***Needs for children ages 6-8 years:***

- yearning for absent parent
- fantasies about parents getting back together
- loyalty conflicts
- concern about parent's well-being
- guilt that they are responsible for the separation

***What to watch for:***

- sadness, grief, crying, sobbing, withdrawal
- fear of losing relationship with parent
- fear of losing order in their lives
- feelings of being deprived

- anger and increased aggressiveness
- difficulty playing and experiencing pleasure

***What you can do to help:***

- provide verbal assurances (Mom and Dad will continue to take care of them)
- assure them they will continue to see both parents (if this is the case)
- give child permission to love other parent
- NEVER criticize the other parent to the child
- NEVER put the child "in the middle"

***Needs for children ages 9-12 years:***

- may see things as black and white: one parent is right; the other is wrong
- may feel shame or embarrassment about parents' separation
- may feel the separation threatens their own identity
- may feel need to overcome a sense of powerlessness
- may feel loyalty conflicts

***What to watch for:***

- physical complaints (headache, fatigue, stomach ache)
- intense anger, especially at parent they see as to blame
- alignment with one parent against the other
- difficulty with peers
- difficulty playing and experiencing pleasure

***What you can do to help:***

- listen to child's feelings and complaints without taking sides or judging
- don't criticize the other parent to the child and don't pressure the child to take sides
- encourage the child to see good in the other parent
- don't fight in front of the child
- say positive things about the other parent occasionally
- support the child's contact with the other parent (if this is possible)

**Helpful children's books on divorce:**

*At Daddy's on Saturdays*, by Linda Walvoord  
*Dinosaurs Divorce*, by Marc Brown  
*Oliver at the Window*, by Elizabeth Shreeve  
*The Best of Both Nests*, by Jane Clarke  
*I Don't Want to Talk About It*, by Jeanie F. Ransom  
*I Live with Daddy*, by Judith Vigna

## Children Coping with Emergencies

Providers should try their best to remain calm during an emergency which is why drills are so important: the more preparation you make for emergencies the better prepared and calmer you will be if there is an actual emergency situation.

The mental health impact of children should be considered when covering emergency preparedness. Sometimes adults overlook what a situation can do to the mental health of a child. During an emergency people can become panicked, children are sometimes rearranged, loud sirens or whistles may be going off, and a sense of urgency is in the air. Even the youngest children can notice this stress and the same way adults react negatively to stress so can children.

- **Talk to children about what is going to happen** before, during and after a drill- even if the children are very young. Easing their confusion of what is going on will help relax a child during the situation.
- **Prepare children for loud noises.** Some children react very negatively to loud noises and just need coaching to cover their ears before a siren goes off.
- **Try to keep children with the same caregivers during drills and emergencies.** Children will be calmer and feel more secure with their primary caregiver.
- **Sing or use a quiet voice even during the most hectic times.** Children will feed off the provider's mood whether they are flustered or composed.

It's important to prepare children for emergencies, but not frighten them. Children's books are a timeless resource to help guide the discussion. Some books that can help:

*Clifford and the Big Storm*, by Norman Bridwell

*Franklin and the Thunderstorm*, by Paulette Bourgeois

*Go Away, Big Green Monster!* By Ed Emberley

*The Flood that Came to Grandma's House*, by C.S. Vendrell and J.M. Parramon

*I'll Know What to Do: A Kid's Guide to Natural Disasters*, by B. Mark, M. Chesworth, and A. Layton

## Grief and Loss

### What is grief?

When someone close to us dies, we experience something called grief. Everyone grieves differently. Grief can be feelings: anger, sadness, worry, relief, fear, numbness. Or it may be thoughts, such as “Who will take care of me now?” or “What will happen next?” Sometimes, grief affects our bodies. We feel sleepy, or have trouble falling asleep. We may not feel like eating. We may have headaches or stomachaches or we may not feel like doing the things we usually like to do, such as playing or going to school. All of these experiences are normal for grieving kids.

How to help a grieving child:

- Answer the questions they ask. Even the hard ones.
- Give the child choices whenever possible.
- Talk about and remember the person who died.
- Respect differences in grieving styles.
- Listen without judgment.
- Hold a memorial service and allow for saying goodbye.
- Take a break. Children grieve in cycles. They may be more inclined to play and divert their focus from the death when the death is recent and adults are grieving intensely. Having fun and laughing is not disrespectful to the person who died and is a vital part of grieving too.

For many children, their first real experience with loss occurs when a pet dies. When a pet dies, children need consolation, love, and support more than they need complicated medical explanations. Children's reactions to the death of a pet will depend upon their age and developmental level.

- Children 3 to 5 years of age see death as temporary and potentially reversible.
- Between ages 6 and 8, children begin to develop a more realistic understanding of the nature and consequences of death.
- Generally, it is not until 9 years of age that children fully understand that death is permanent and final.
- For this reason, very young children should be told that when a pet dies:
  - It stops moving
  - It doesn't see or hear anymore
  - It won't get up again.
- They may need to hear this explanation over and over again.

There is no best way for children to mourn their pets. They need to be given time to remember their pets. It helps to talk about the pet with friends and family. Mourning a pet has to be done in a child's own way. After a pet has died, children may want to bury the pet, make a memorial, or have a ceremony. Other children may write poems and stories, or make drawings of the pet.

When a family member dies, children react differently from adults. Preschool children usually see death as temporary and reversible. Children between five and nine begin to think more like adults about death, yet they still believe it will never happen to them or anyone they know.

Adding to a child's shock and confusion at the death of a brother, sister, or parent is the unavailability of other family members, who may be so shaken by grief that they are not able to cope with the normal responsibility of caring for the child.

A child who is frightened about attending a funeral should not be forced to go; however, honoring or remembering the person in some way, such as lighting a candle, saying a prayer, making a scrapbook, reviewing photographs, or telling a story may be helpful. Children should be allowed to express feelings about their loss and grief in their own way.

Once children accept the death, they are likely to display their feelings of sadness on and off over a long period of time, and often at unexpected moments. The surviving relatives should spend as much time as possible with the child, making it clear that the child has permission to show his or her feelings openly or freely.

The person who has died was essential to the stability of the child's world, and anger is a natural reaction. The anger may be revealed in boisterous play, nightmares, irritability, or a variety of other behaviors. Often the child will show anger towards the surviving family members.

Resources to help you identify symptoms of severe stress and grief reactions are available at the National Association of School Psychologist's website— [www.nasponline.org](http://www.nasponline.org).

Information above from The Dougy Center, The National Center for Grieving Children & Families ([www.dougy.org](http://www.dougy.org)), and The American Academy of Child & Adolescent Psychiatry, [www.aacap.org](http://www.aacap.org)

Helpful children's books about death and dying:

*The Fall of Freddie the Leaf: A Story of Life for All Ages*, by Leo Buscaglia

*Jim's Dog Muffins*, by Miriam Cohen

*Lifetimes: The Beautiful Way to Explain Death to Children*, by Bryan Mellonie with Robert Ingpen

*Nana Upstairs & Nana Downstairs*, by Tomie dePaola

*The Saddest Time*, by Norma Simon

*The Tenth Good Thing About Barney*, by Judith Viorst

*You Hold Me and I'll Hold You*, by Jo Carson

## Separation Anxiety

At birth, infants have no concept of their caregivers as separate from themselves. At around six to eight months, infants begin to understand that parents and caregivers are separate. By around nine months of age, infants can visualize a mental image of their caregiver and realize they are GONE! They have no way of understanding whether or when their parent or caregiver will return.

This experience makes many infants and young children anxious. This can happen even when a caregiver goes into the next room or an early childhood teacher takes an afternoon break. This can be a challenging time but it is the beginning of the period of infant development called “separation anxiety” and is a sign of developmental gains.

### Facts about separation anxiety

**Infants:** Separation anxiety develops after a child gains an understanding of object permanence. Once an infant realizes you're really gone (when you are), it may lead to crying each time you leave the room. Although some babies display object permanence and separation anxiety as early as 4 to 5 months of age, most develop more serious separation anxiety at around 9 months. The reaction can be worse if an infant is hungry, tired, or not feeling well.

**Toddlers:** Some toddlers skip separation anxiety in infancy and start demonstrating challenges at 15 or 18 months of age. As children develop independence during toddlerhood, they may become even more aware of separations. Their behaviors at separations will be loud, tearful, and difficult to stop. Separations are more difficult when children are hungry, tired, or sick.

**Preschoolers:** By the time children are 3 years of age, most understand the effect their anxiety and pleas at separation have on us. It doesn't mean they aren't stressed, but their reaction may be more for the purpose of changing our minds about leaving. Be consistent; don't return or cancel plans based on a child's pleas. Explain where you're going and when you will return, and then return when you say you will.

### Ways parents can help ease their child's separation anxiety

- Visit the child care program with your child before the first day of care.
- Drop your child off healthy and well-rested.
- Create brief, but loving good-bye rituals, such as a special secret handshake, triple kisses at the cubby, or the “Kissing Hand” ritual.
- Offer a “transitional object”: a family photo, blanket, or cuddly toy from home, reminding your child of your love and that you will return.
- Be consistent. Try to do the same drop-off with the same ritual at the same time each day. A routine provides comfort and allows your child to build trust in you.
- When separating, give your child your full attention and be loving and affectionate.
- **Never “sneak out”** without saying goodbye; this undermines your child's trust and he will always be fearful of you “slipping away” when he is not looking.
- Resist the temptation to come back to check on your child (this can be done with a phone call to your child's teacher).

- Be specific, child style. When you discuss your return, provide specifics that your child understands. If you know you'll be back by 3:30 pm, explain this on your child's terms; for example, say, "*I'll be back after nap time when you're finishing your afternoon snack.*"
- Avoid sharing your own anxieties over separation with your child. This will only confirm what she already fears.
- Practice being apart. Schedule play dates, allow friends and family to provide child care for you (even for an hour) on the weekend. Before starting child care or preschool, practice your good-bye ritual. Give your child a chance to prepare, experience, and thrive in your absence!

### **Ways child care providers can help ease separation anxiety**

- Play separation and return games like "Peekaboo" and "Where's the Baby?" with infants and toddlers.
- When parents have completed their good-bye ritual let the child know you are there and it is ok to feel sad or to cry. Remind the child when the parent will return.
- After the parent leaves invite the child to participate in a favorite activity.
- Offer comfort during the day and positive encouragement for participation in activities.
- Repeat familiar nap or mealtime routines from home.
- Read books about separating from parents:
  - Are You My Mother?* By P.D. Eastman
  - The Good-Bye Book*, by Judith Viorst
  - The Kissing Hand*, by Audrey Penn
  - Owl Babies*, by Martin Waddell

If a child's anxiety worsens despite using the above techniques, or lasts for more than four weeks, and the child is unable to do anything without the parent or primary caregiver, talk with the family about professional intervention.

Children are identified as having separation anxiety disorder, a much less common mental health condition, when they experience developmentally inappropriate distress, or excessive anxiety around separation for at least four weeks. Intervention is necessary for these children and there are treatments that will spare them a great deal of distress as they grow.

### Communication is the Key

The daily interactions we have with children set the tone for the kind of relationship we have with them. Language that helps children feel safe and supported promotes positive emotional growth and development.

- Individually greet children and parents as they arrive in the morning and tell them good-bye as they leave at the end of the day.
- Weave nurturing moments into each day with children.
- Get to know each child as an individual.
- Talk to young children using language they understand.
- Clearly and simply state what you expect the children to do.
- Have age appropriate expectations.
- Use positive communication – this can help reduce undesirable behavior.
- Show children by modeling or using pictures.
- Be enthusiastic and generous with encouragement.
- Tell a child what to do instead of what not to do.

*Examples:*

Avoid Saying	Say
<b>Don't run!</b>	Use your walking feet.
<b>Quit climbing on the chair.</b>	Sit with your feet on the floor.
<b>Don't touch!</b>	Look with your eyes.
<b>No yelling.</b>	Use your inside voice.
<b>Stop playing with your food.</b>	Food goes on the spoon and in your mouth.
<b>Don't squeeze the kitten.</b>	Hold the kitten gently.
<b>No hitting!</b>	Hands are for playing and hugging. Use your words if you're upset (give child appropriate words to use).
<b>Don't throw your truck.</b>	Roll your truck on the floor.

*Following are some ideas for supporting the development of communication skills:*  
Adapted from **Zero to Three – Supporting Your Child's Communication Skills**

**Respond to baby's gestures, looks and sounds.** When he puts his arms out to you, pick him up, kiss him and use simple words. "You want up." When he coos, coo back. When he gazes at you, make eye contact and talk with him. These immediate and attuned responses tell the baby that his communications are important and effective. This will encourage him to continue to develop these skills.

**Talk with and listen to the children.** When you talk with children in your care, give them time to respond. Make eye contact on their level. This will let them know you want to hear what they have to say. Ask open-ended questions: "How do you feel about today's rainy weather?" "Where do you think the rain goes?" "How do you think the rain helps flowers grow?" "Why is the sky so gray?" By talking and interacting with children you help them see themselves as a good communicator and motivate them to keep developing these skills.

**Help children build on their language skills.** "So you are pretending to be a hungry caterpillar who wants to eat some food? What kind of food? Let's name all the things you want to eat."

**Teach children about non-verbal communication.** "Luis, do you see how Andi is holding her hands up to cover her face? She doesn't like it when you throw the ball so hard. I know you can throw it softer so she will want to keep playing catch with you."

**Respect and recognize each child's feelings.** Children are far more likely to share their ideas and feelings if they know they won't be judged, teased, or criticized. You can empathize with a child's experience, yet disagree with his behavior. For example, "I know you're scared to sleep alone, but you need to stay in bed. Would you like some quiet music on?" Or, "I know you're angry but you can't throw the blocks. Here's a pillow you can punch instead."

**Help children develop a "feelings" vocabulary.** Provide the words for their experience. "You're sad because Daddy left for his trip." Keep in mind that feelings are not good or bad, they just are. Sometimes parents are afraid that talking about an intense feeling will escalate it; but many times the opposite happens. When children feel that their feelings and experiences are respected, they are often able to move on more easily. \*See activities on next page.

**Narrate what you do as you go through your daily routines.** This helps children connect words with objects and actions. "I'm washing the dishes. I'm squeezing the yellow dish soap into the warm water." Talk about what you're doing as you care for your child. "Here we go into the bathtub. You're tummy, arms, and legs are getting all wet. Rubber Ducky is having a bath too." Talk as you play together: "You're brushing your dolly's hair. She has long hair. Are there any tangles?" With verbal toddlers, you can create a tradition where each person at the table shares something about their day. Ask children questions about their day. Encourage them to ask you things too.

**Encourage pretend play.** Children often express themselves more freely when they're pretending. It may feel safer to talk about how Teddy Bear is afraid of the dark, than how the child is. Pretend play is also a chance to take on different roles and to act out what different people might say, think or do. This develops language as well as social skills like empathy.

**Make your requests clear, simple, and appropriate for the child's age and ability.** For a one-year-old, give one step directions like, "Go get the ball." For an 18-month-old, give two-step commands like, "Please go to your room and get your shoes." Be sure you have your child's attention first, by calling his name or gently touching him and looking directly at him at his eye level. You can ask an older child to repeat the request to make sure he heard and understood the communication.

**Be a good role model.** Your children are watching you very carefully. If you talk to others with kindness and respect, they will likely follow your lead and take on your manner and tone as they become more verbal. And, when you expect this kind of respectful communication from others, you are modeling how they should expect to be treated by others as well.

**Social-Emotional Teaching Strategies** – adapted from [www.BuildingBlocksLanguage.com](http://www.BuildingBlocksLanguage.com)

**Parents and educators can help children build a more complex social-emotional vocabulary through play, book reading, and special activities.**

1. **Books:** It will come as no surprise to hear that books are an excellent way to expose young children to a variety of language & concepts, including social-emotional vocabulary.

*When Sophie gets Angry, Really Angry*, by Molly Bang

*Today I Feel Silly & Other Moods That Make My Day*, by Jamie Lee Curtis

*Have You Filled a Bucket Today?: A Guide to Daily Happiness for Kids*, by Carol McCloud

*I Was So Mad (Little Critter)*, by Mercer Mayer

2. **Feelings activities:** Plan special activities and games that reinforce understanding & use of feelings words.

**“I Feel...” Poster:** Create a feelings poster in your home or in the classroom that depicts a variety of facial expressions. Take a moment in the morning to check in on how your child is feeling as she is brushing her teeth or eating breakfast. Check in again later in the day. When your child is talking about what happened during her day at preschool, encourage her to tell you how situations and events made her feel, by pointing to a facial expression and using the appropriate word (i.e., “How did you feel when Jack knocked your block tower down?”). You can create a feelings poster yourself or purchase a ready-made poster. The key is to build in new words & pictures gradually. Draw the child’s attention to the facial expression. Talk about a time he or she felt that way. Talk about what he or she can do to deal with that emotion. Communication is the key.



<http://buildingblockslanguage.com/2014/02/07/building-social-emotional-vocabulary-in-early-childhood/>

**Feelings Dice:** Create a set of feelings dice with your child by gluing pictures of faces depicting various emotions on each side of a small box. Children can toss the dice, label the feeling, and describe a time they felt that way.



**Sing a Feelings Song:** Modify “*If You’re Happy and You Know It...*” to include other feelings and sing about what you can do when you feel that way. For example, “*If You’re Sad & You Know It, Hug a Friend.*”, or “*If You’re Angry & You Know It, Take a Break.*”

**Resources for communication and language development:**

Zero to Three: National Center for Infants, Toddlers, and Families.

<http://www.zerotothree.org/child-development/early-language-literacy/tips-tools-early-lit-and-lang.html>

Enhancing Emotional Vocabulary in Young Children: Vanderbilt University.

<http://csefel.vanderbilt.edu/modules/module2/handout6.pdf>



## Infant Crying

“By crying, babies can express their pain, hunger, anger and boredom but sometimes they cry for no specific reason” – *Centre of Excellence for Early Childhood Development*

Crying is an important means of communication for babies during early infancy – that is from birth to three months of age. At this stage in their development, infants almost entirely rely on caregivers to meet their needs. As a result, infant crying can assume an important role in ensuring the survival, health and development of the child.

### What do we know about infant crying?

- Crying is the main way of communicating for babies less than 3 months old.
- By crying, babies can express their pain, hunger, anger and boredom but sometimes they cry for no specific reason.
- Even healthy babies who get excellent care cry a lot.
- In the first 3 months of life, around 25% of babies cry for more than three and a half hours each day.
- At around 3 months old, babies start to cry less. They begin to babble and to move more easily, and start to be able to express themselves in ways other than crying.
- Persistent crying that seems to have no reason can make parents and caregivers feel worried, upset or out of control.

**Calming a crying baby can be difficult** and is sometimes a “trial and error” process.

Consider these questions:

- Is the baby hungry?
- Does the baby need to be burped?
- Does the baby need a dry diaper?
- Is the baby sleepy?
- Is the baby in pain?
- Is the baby sick or feverish?
- Is the baby bored or lonely?
- Is the baby over-stimulated?
- Is the baby over- or under- dressed?

### Things to try

- Move the baby to a new position.
- Hold the baby close to you and gently stroke or pat the back.
- Dim the lights.
- Rock the baby, either in rocking chair or in your arms as you sway from side to side.
- Offer the baby a pacifier (if the parent provides one).
- Sing to baby, or play soft music.
- Take the baby outside for a walk.
- Don't use food as a first solution, especially if the baby has eaten recently.

- Sometimes if all else fails, the best approach is to simply leave the baby alone. Many babies cannot fall asleep without crying, and will go to sleep more quickly if left to cry for a few minutes. Be sure to follow Infant Safe Sleep guidelines for safety.

*When a strategy doesn't work, don't blame yourself. Try something else until you discover what works for your individual baby in that specific moment in time. (A strategy that didn't work yesterday may work today.)*

The more relaxed you remain, the easier it will be to console the baby. Even very young babies are sensitive to tension around them and react to it by crying. Don't take the baby's crying personally and no matter how impatient or angry you feel.....

**NEVER SHAKE THE BABY! Shaking an infant can cause blindness, brain damage or even death!**

**The Period of PURPLE Crying** is a new way to help parents and caregivers understand the time in a baby's life which is a normal part of every infant's development. It is confusing to be told your baby "has colic" because it sounds like it is an illness or a condition that is abnormal. When the baby is given medication to treat symptoms of colic, it reinforces the idea that there is something wrong with the baby, when in fact, the baby is going through a very normal developmental phase.

The Period of PURPLE Crying begins at about 2 weeks of age and continues until about 3-4 months of age. There are other common characteristics of this phase, which are described in the PURPLE acronym. *All babies go through this period.* It is during this time that some babies can cry a lot and some far less, but they all go through it. When babies are going through this period they seem to resist soothing. Nothing helps. Even though certain soothing methods may help when they are simply fussy or crying, bouts of inconsolable crying are different. Nothing seems to soothe them.

**Resources:**

**Period of PURPLE Crying:** <http://www.purplecrying.info/>

**Infant Massage:** This can be a great way to help calm your child, provide a bonding and nurturing environment, help with longer sleep and other health benefits.

**-Oklahoma Infant Massage Institute-** offers free massage lessons for parents and other training classes: 1413 S Boulevard Edmond, Oklahoma (405) 330-1311

**-Infant Massage USA:** <http://www.infantmassageusa.org/learn-to-massage-your-baby/educator-directory/>

**-International Association of Infant Massage:** <http://www.iaim.net/>

**-Loving Touch:** <http://www.lovingtouch.com/>

**Oklahoma Association of Infant Mental Health** <http://www.okaimh.org/index.html>

**Zero to Three-National Center for Infants, Toddlers, and Families**

<http://www.zerotothree.org/>

## Positive Guidance and Setting Limits

### Guiding children's behavior

Children need adults to teach, guide, and support them as they grow and learn. Child care providers play an important role in guiding children's behavior in positive and supportive ways. The most appropriate ways to guide children's behavior are different at different ages, and will depend on their developmental abilities and needs.

### Common strategies for guiding children's behavior

- Keep rules simple and easy to understand. Discuss rules with children and write them down. Repeat the rules often. Remember too many rules set everyone up for failure. A few rules that work well:
  1. Be kind to each other.
  2. Take care of our toys.
  3. Say please and thank you.
  4. Use our walking feet inside.
- Say what you mean. Keep sentences short and simple. Focus on *what to do* rather than what not to do. For example try saying "Slow down and walk" instead of "stop running".
- Talk **with** children – not "**at**" them.

### Managing Challenging Behaviors

#### Classroom Tips to Decrease or Prevent Biting and Other Challenging Behaviors

Adapted from Kennell, G. (2002). *No Biting: Policy and Practice for Toddler Programs*.  
Readleaf Press

### Provide a supportive environment

- Have duplicates of the new and favorite toys to reduce frustration.
- Keep favorite toys available, but avoid over-stimulation by making sure all the toys aren't available to the children at once.
  - Rotate toys, storing some away for a while, and then bringing them back out. This also keeps children interested in the environment.
- Provide small, private spaces where children can go to be alone. Remember supervision is important so make sure the child can still be seen and heard.
  - Toddlers are working on understanding spatial relationships; that's why they like to try fitting themselves into small spaces. Spaces under lofts, tables, or in shelving units are usually popular.
- Provide several soft areas in the room. Use pillows, rugs, and comfortable upholstered furniture to provide coziness.
- Have safe materials visible and available to children at the children's level so they can use them without an adult having to get them.

- Create a variety of activity centers to discourage toddlers from bunching up in one area.
- Children often want to go where the adults are, so adults need to spread themselves throughout the space.

### **Provide a consistent, flexible schedule**

- Keep the daily schedule consistent, so it is predictable for children. Being able to predict what will come next is empowering for children.
- Simplify the daily routine, so children aren't asked to transition from one activity to the next too often.
- Allow for flexibility to meet children's individual needs.
  - Children need to eat when they are hungry and sleep when they are tired, regardless of whether it's snack or naptime.
- Talk about unavoidable changes in the schedule and be understanding of children's reactions to them.
- Provide several times each day for children to go outside.
- Don't rush children through activities or routines.
- Keep waiting to a minimum.

Most teachers are surprised when they learn how long children are actually waiting between activities. Try asking an objective person to observe your program and keep track of actual waiting time in minutes. To put waiting time into perspective, take the number of minutes toddlers must wait, put a zero at the end of it, and reflect on how you would react to the waiting time in that situation. For example, if the actual waiting time between an activity and lunch is seven minutes, consider how you would respond to a seventy minute wait in a similar situation. Also remember, you would be expected to remain calm and choose "appropriate activities" during those seventy minutes.

### **Provide a variety of sensory activities and materials**

- Provide a wide variety of soothing materials and activities.
  - Scarves and dress-up materials that are soft and silky
  - Painting and play dough, daily
  - Sand and water table, at least several times a week (individual basins can be used if your program doesn't have a sand and water table)
- Provide many cause and effect toys that toddlers can act upon to make them "do something".
  - Musical instruments, busy boxes, pounding boards, jack in the boxes, etc.
- Provide opportunities for toddlers to put collections of small, choking safe objects (clothespins, jar lids, juice can lids, etc.) in containers to carry and dump out.
- Instead of planning teacher-directed activities, offer interesting materials and experiences. Observe the children's reactions to the materials then plan how to

further their interest. Offer the same thing over and over, so that children have many opportunities to experiment.

- Offer adult-initiated activities that are spontaneous, short, and optional, such as songs, stories, and finger plays.
- Do not expect toddlers to have formal circle time or to sit in whole group activities.

### **Provide gentle and empathetic interactions**

- Show children what empathy looks and sounds like; model it in your interactions with them.
- Respond positively to children.
- Help children to identify and name their feelings. Say things such as, “Robin, you look frustrated to me. You really wanted to play with the truck, and Sarah has it.”
- Show and tell children how to use language to express feelings and state their needs and wants. Say things such as, “Robin, you can tell Sarah, ‘my turn next’ that way she knows you are waiting for the truck.”
- Encourage children to comfort themselves by using transitional items such as stuffed animals or blankets brought from home.
- Comfort children with soothing voice tones and physical actions such as hugs, a thoughtful hand on a child's shoulder, or a pat on the back.
- Help children fix mistakes. For example, if a child looks genuinely upset that she hurt another, you can say, “Sammy, you look upset that Lonetta is crying. I wonder if she'd like a hug?” Other possible ways to fix a mistake; help rebuild a knocked down tower or fetch ice for a bite.

Despite even the best prevention efforts of the best caregivers, biting and other challenging behaviors still happen. When they occur, caregivers must be prepared to respond appropriately and effectively and be willing to ask for help when necessary. The **Child Care Warmline (888-574-5437)** is available to assist caregivers who are dealing with biting and other challenging behaviors.

### **Preventing expulsions and suspensions**

Unfortunately, children with behaviors that adults view as “difficult” or “problematic” are sometimes shuffled from one early childhood program to another because of the comfort level of the provider not the individual situation of the child. Adults sometimes forget they are working to serve the children and provide the best care possible.

Expulsion does the opposite of that.

The first years of a child's life are the building blocks of foundation for learning, health, and wellness. High quality care for children, specifically those that are not yet in kindergarten, has a huge impact in the most meaningful way. This is especially true for children in at-risk environments.

Expelling a child (telling a parent their child can no longer attend), can give the child the label of a “bad child”. This may influence how other early childhood programs react to the child and may keep the child from being excited about school. This is a toxic situation, especially for early learners.

If a provider is caring for a child with difficult behavior and is thinking about expulsion or suspension they should take into consideration the *child's social-emotional* and *behavioral development* as well as *their home situation*. They can ask the questions:

- Why am I considering removing this child from my care?
- Will expelling this child truly help them in their life?
- Am I only interacting with the child when they are misbehaving, or do I encourage them at positive times as well?
- Has a deep conversation about this child occurred more than once with the family of the child?
- Are there any resources available that can help this child and family?

Children with challenging behaviors that then go through a stressful experience like being expelled from preschool will only be pushed back further and further when it comes to their development and self-esteem. Those that don't benefit from early childhood education are the ones that don't attend and they aren't in attendance because they were kicked out.

**Ways to eliminate expulsion and suspension from child care, as recommended by The U.S. Departments of Health and Human Services and Education are:**

- Develop and clearly communicate preventive guidance and discipline practices.
- Develop and clearly communicate expulsion and suspension policies and implement those policies uniformly and without bias.
- Invest and grow the skills of the early childhood workforce with a focus on:
  - Children's social-emotional and behavioral health
  - Strengthening partnerships with families
  - Employing strategies to prevent and correct biases
  - Conducting universal developmental and behavioral screening and appropriate follow-up
- Set goals and analyze trends in data to assess progress in reducing expulsion and suspensions.
- Make use of free resources to enhance staff training and strengthen family partnerships.

### **Time In: Building a Comfort Corner**

Consider “Time In” as an alternative to “Time Out” as a tool for guiding children’s behavior.

#### **Issues with Time Out:**

- Time Out usually involves isolation, causing a child stress and discomfort. Isolation teaches nothing of value and the child does not learn from the experience.
- Time Out is the absence of actual teaching. A child in Time Out probably needs some guidance and instruction.
- Time Out is not usually related to the problem behavior, so the child doesn’t relate the discipline to the event that precipitated it.

Instead of a “*Time Out Chair*”, the “***Comfort Corner***” is a designated area in your room that is used for reflection, lowering of intensity, regrouping, and child-directed down time. It’s a place where comfort is available, and company too, if requested.

#### **This is how it works:**

- Create a designated area in your room with a comfy chair, or a soft rug and some pillows.
- Add books and soft toys (consider toys that can be squeezed and squished for releasing pent-up feelings).
- Consider adding soothing music and headphones to listen.
- When children get upset or behave unacceptably “invite” them to spend some time in the Comfort Corner.

A child isn’t sent to Time In, they are invited to go. The child does not have to sit and wait in the Comfort Corner; he can engage in comforting, soothing, and appropriate play until he feels ready to join the group.

You will find some children using the Comfort Corner on their own when they realize the benefits – and this means they are learning to recognize and deal with their feelings appropriately!

Time In teaches children how to nurture and care for themselves and learn about self-control. With a Comfort Corner you are teaching children vital skills they will use for a lifetime, and you are building a relationship with each child that is defined by trust, respect, and confidence.

**For more information:**

Gilliam, W. S. (2005). Prekindergarteners left behind: Expulsion rates in state prekindergarten systems. New Haven, CT: Edward Zigler Center in Child Development and Social Policy. Retrieved from:

[http://ziglercenter.yale.edu/publications/34774\\_National%20Prek%20Study\\_expulsion.pdf](http://ziglercenter.yale.edu/publications/34774_National%20Prek%20Study_expulsion.pdf)

Administration For Children & Families: Equity and Excellence in the Earliest Years:  
Action on Expulsion and Suspension in Early Childhood Settings

December 16, 2014 | Shantel Meek

<http://www.acf.hhs.gov/>

[http://www.positivediscipline.com/articles/Time\\_Out\\_for\\_Children.html](http://www.positivediscipline.com/articles/Time_Out_for_Children.html)

[http://www.naturalchild.com/guest/peter\\_haiman.html](http://www.naturalchild.com/guest/peter_haiman.html)

## Supporting Children and Families in the Military

Military families want what is best for their children just like all families. They often look for information on how to help their children develop and cope with the stress that can come with being in a military family. **Zero To Three** worked with the **United States Marine Corps Personal and Family Relations Division** to develop *A Professional Guide for Supporting Babies and Toddlers in Military Families*.

A series of five brochures was developed that focus on the unique experience of parenting a baby or toddler, particularly during times of stress and separation that military families experience.

**The five brochures are:**

- ***Deployment: Keeping Relationships Strong*** which focuses on how to help a baby or toddler feel secure by keeping the parent and child connections strong – whether a parent is at home or halfway across the world.
- ***Homecoming*** focuses on how to help a baby or toddler feel secure during the homecoming by having realistic expectations as family members reconnect and begin to discover a “new” normal.
- ***New Families*** focuses on how to be supportive when expecting a baby and after the baby is born by building strong and nurturing relationships around and with the baby.
- ***Combat Stress*** focuses on how parents support their young child by taking steps to heal. No one suffers a stress injury alone. This brochure provides information about combat and operational stress injuries, steps to help heal them, and people and organizations ready to offer support.
- ***Homefront*** focuses on how parents at home take better care of their baby or toddler by taking care of themselves.

The key messages found in each guide that you might want to discuss with the families are:

- **It's all about relationships.** The relationships surrounding babies, especially those with their parents and other trusted caregivers shape how they experience the world and see themselves.
- **Babies and toddlers communicate their feelings and needs through their behavior.** Their behavior has meaning.
- **The little things you say and do day by day make a big difference.** Everyday routines and activities such as bathing, dressing, eating, and playing together are rich learning opportunities for parents, babies, and toddlers.
- **How you are is as important as what you say and do.** Babies tune into feelings of their parents and other trusted adults.

- **Babies and toddlers are resilient.** Adults who are loving, trusted, and responsive can help babies and toddlers manage during difficult times.
- **Taking care of yourself is a key** way to take care of your baby or toddler. When parents feel nurtured, they have more energy, patience, and focus.

### **Resources for families**

**MilitaryHOMEFRONT:** [www.militaryhomefront.dod.mil](http://www.militaryhomefront.dod.mil) is the official Department of Defense Website for reliable quality of life information designed to help troops and their families, leaders, and service providers.

**Military OneSource:** [www.militaryonesource.com](http://www.militaryonesource.com) is available 24/7 to connect families with services including car repair, money management, child care, spouse employment, counseling, and relocation. Or call 1-800-342-9647.

**ZERO TO THREE:** [www.zerotothree.org](http://www.zerotothree.org) offers a wealth of information on the social, emotional, and intellectual development of babies and toddlers. The military webpage supports military professionals and parents with postings of monthly articles, information, and events at [www.zerotothree.org/military](http://www.zerotothree.org/military) .

## Toilet Learning in Child Care

Learning to use the toilet is an important developmental milestone that often occurs during the years a child has entered an out-of-home child care program. Parents and child care providers should work as partners to support each other and the child during this learning process.

### When is a child ready?

Every child develops differently, so the start of toilet learning should be based on the child's developmental level rather than age or the adult's eagerness to start. Attempting toilet learning before a child is ready can create stress and anxiety for the child and delay the process. Also try not to begin while the child is experiencing a disruption or change in life – such as the birth of a new sibling.

Signs of readiness include an increased awareness of a need to go, curiosity in other's bathroom habits, demonstrated interest in the toilet, having words for using the toilet and an understanding of “wet” versus “dry”. In order to start learning to use the toilet a child must be able to:

- Follow simple instructions.
- Cooperate with adults.
- Stay dry for at least two hours at a time during the day.
- Feel the physical sign of the *need* to go to use the toilet.
- Understand words about the toileting process.
- Use words to express the need to use the toilet.
- Get to and from the bathroom area.
- Be able to pull pants and diapers off or down.

### Techniques for success

- Include toilet learning activities as part of the daily curriculum. Read stories, sing songs and play games about using the toilet or “potty”.
- Because toilet learning involves so many steps (discussing, undressing, going, wiping, flushing, and handwashing), reinforce the child's success at each step.
- Accept (and help the child accept) that occasional accidents are normal.
- Never force a child to sit on the toilet for long periods of time.
- Children should be dressed in clothing that can be easily pulled up and down on their own.
- Provide child-sized toilets or have an adaptive seat and a secure step stool to make them feel child-sized.

If a child resists toilet learning, he or she may not be ready for the process or find it too stressful. If a power struggle begins, wait a few weeks and try again. Remember to transfer responsibility to the child, provide lots of positive feedback for using the toilet, and change wet or soiled clothing immediately.

### **Adaptations for children with special needs**

A child with special needs may require a unique set of plans and procedures, more time, and more flexibility from adults, but the same toilet learning methods apply. Simplify expectations, be persistent, create small, achievable steps and acknowledge progress along the way.

### **Important points to remember**

- Parents and caregivers cannot control the toilet learning process.
- Do not reward with candy, treats or special prizes when a child uses the toilet.
- Do not use any forms of physical or verbal punishment for toileting accidents.
- Your positive and encouraging words, whether successful at using the toilet or not, are what the child needs and wants to hear.
- Children must WANT to use the toilet. Emotional readiness is often overlooked during the toilet learning process.
- Most children develop the ability to use the toilet between the second and fourth birthdays.
- Nighttime dryness may or may not happen at the same time as daytime dryness.

Toilet learning is a multi-step process and can take from two weeks to six months. Setbacks are common and should not be considered failures. Children will be more successful when parents and child care providers agree on strategies and techniques and work together as a team.

## Constipation in Young Children

When a child has hard stool that causes difficult and painful bowel movements, it is called constipation. Constipation is common in children and some possible reasons are:

- Holding back bowel movements
- Inadequate fluid intake
- Diet
- Special needs

### **Holding back**

The large intestine's job is to move the body's waste and absorb water and salts from the contents until stool is formed and then eliminated during a bowel movement. Sometimes constipation starts when one hard stool caused pain. The child may respond by "holding back" and resisting the urge to have a bowel movement the next time. This can cause gas, pain, and decreased appetite, making the problem worse. Children may also ignore the urge to use the toilet when they are busy playing, involved in an activity, or are uncomfortable using a toilet away from home.

### **Inadequate fluid**

Drinking too little fluid, especially on hot days or when a child has a fever can make a child constipated.

### **Diet**

A diet that is high in refined sugars, starches and milk products, but low in vegetables, fruits, and whole grains (fiber) can contribute to constipation. Fiber refers to the parts of plants that are eaten and not digested. Dietary fiber plays an important part in keeping the stool soft and easy to pass.

### **Special needs**

Some children with special needs will experience constipation more frequently than typically developing children. This may be due to limited physical activity, medications, poor muscle tone, and inadequate food and fluid intake.

### **What you can do:**

- Use matter-of-fact words that are non-judgmental to help children learn to manage their toileting needs.
- Make sure young children have fluids at meals and water is available throughout the day.
- Serve nutrition foods high in fiber. Offer plenty of fruits and vegetables such as apricots, pears, plums, prunes, peaches, berries, avocados, tomatoes, carrots, broccoli, peas, beans and whole grains like oats, brown rice, barley, and whole wheat.
- Communicate with families about the child's bowel habits. Respect cultural expectations of toileting. Provide information about a healthy diet that includes lots of fruits, vegetables and whole grains.

- Be sure to include toileting and elimination issues in a child's IEP or special health care plan.

**When to contact a health professional**

Sometimes a child may need help from their health care provider for constipation. A pediatrician may recommend stool softeners or laxatives and will evaluate for other problems. Ask the parents to contact their health care provider if the child has not had a bowel movement in more than three days or if the child is experiencing pain that becomes worse.

## Understanding Early Childhood Sexual Development

*Adapted from Sexual Development and Behavior in Children, The National Child Traumatic Stress Network.*

Like all forms of development, sexual development begins at birth. Sexual development includes not only the physical changes that occur as children grow, but also the sexual knowledge and beliefs they come to learn and the behaviors they show. Any given child’s sexual knowledge and behavior is strongly influenced by:

- The child’s age
- Observed behaviors of family and friends
- Cultural and religious beliefs that are taught

### Common Sexual Behaviors in Childhood

<p><i>Preschool children (less than 4 years old)</i></p>	<ul style="list-style-type: none"> <li>• Exploring and touching private parts, in public and in private.</li> <li>• Rubbing private parts (with hand or against objects).</li> <li>• Showing private parts to others.</li> <li>• Trying to touch mother’s or other women’s breasts.</li> <li>• Removing clothes and wanting to be naked.</li> <li>• Attempting to see other people when they are naked or undressing (such as in the bathroom).</li> <li>• Asking questions about their own and others’ bodies and bodily functions.</li> <li>• Talking to children their own age about bodily functions such as “poop” and “pee”.</li> </ul>
<p><i>Young children (approximately 4-6 years)</i></p>	<ul style="list-style-type: none"> <li>• Purposely touching private parts (masturbation), occasionally in the presence of others.</li> <li>• Attempting to see other people when they are naked or undressing.</li> <li>• Mimicking dating behavior (such as kissing or holding hands).</li> <li>• Talking about private parts and using “naughty” words, even when they don’t understand the meaning.</li> <li>• Exploring private parts with children their own age, such as playing “doctor”, “I’ll show you mine if you show me yours,” etc.</li> </ul>

<i>School-Aged Children (approximately 7-12 years)</i>	<ul style="list-style-type: none"><li>• Purposely touching private parts (masturbation) usually in private.</li><li>• Playing games with children their own age that involve sexual behavior, such as “truth or dare”, “family”, or “boyfriend/girlfriend”.</li><li>• Attempting to see other people naked or undressing.</li><li>• Looking at pictures of naked or partially naked people.</li><li>• Viewing/listening to sexual content in media (television, movies, games, the internet, music, etc.).</li><li>• Wanting more privacy (for example, not wanting to undress in front of other people) and being reluctant to talk to adults about sexual issues.</li><li>• Beginning of sexual attraction to/interest in peers.</li></ul>
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Just because a behavior is typical doesn't mean the behavior should be ignored. Often, when children participate in sexual behavior it indicates that they need to learn something. Teach what the child needs to know, given the situation.

Too often, children get the majority of their sexual education from other children and from media sources such as television shows, songs, movies, and video games. Not only is this information wrong, it may have very little to do with sexual values that parents want to convey.

Controlling media exposure and providing appropriate alternatives is an important part of teaching children about sexual issues. Get to know the rating systems of games, movies, and television shows and make use of the parental controls available through many internet, cable and satellite providers.

**For more detailed information on responding to and educating about sexual behaviors please refer to the full handout, *Sexual Development and Behavior in Children* in the appendices section.**

**Additional information and resources can also be requested by contacting the Child Care Warmline at 888-574-5437.**

# **Chapter 5: Injury Prevention and Infection Control**





## Chapter 5: Injury Prevention and Infection Control

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## **Childhood Injury Prevention**

Injury prevention is the understanding that injuries are not random uncontrollable events, but preventable, with identifiable risk factors. Many injuries happen in predictable, preventable ways.

As a child care provider, you are responsible for the health and safety of the children in your care. A healthy and safe environment for children means they can live and play in your facility or home free from harm.

### **Keys to a SAFE environment**

- **Supervise** – close supervision of children at all times.
- **Anticipate** – ask yourself “What are the possible hazards?”
- **Formulate** – make a plan by asking “What do I do if.....?”
- **Educate** – educate all providers and children of possible hazards in the environment.

Teach children safety rules and awareness throughout the day, every day.

### **Steps to prevent injuries:**

- Never leave infants or young children alone on changing tables, beds, couches, vehicles, or any surface from which they can fall.
- Use only cribs and portable cribs that meet current federal safety guidelines.
- Keep a harness or safety strap on babies in high chairs.
- Keep play areas uncluttered.
- Keep playground equipment in good condition.
- Remove poisons and toxic products or keep in locked cabinets out of reach.
- **SUPERVISE! SUPERVISE! SUPERVISE!** Provide adequate staff on the playground and in classrooms to supervise all activities.
- Learn and practice CPR and relief of airway obstruction.

## Bicycle safety

### “Use your head, wear a helmet.”

The single most effective safety device available to reduce head injury and death from bicycle crashes is a bicycle helmet.

- Enforce the rule that **children must wear a helmet EVERY TIME** they ride a bike, riding toy, scooter and skateboard. This includes motorized riding toys.
- Make sure the helmet sits flat atop the head, has strong, wide straps that fasten snugly under the chin, and meets the Consumer Product Safety Commission Standard (it should have a CPSC sticker).
- The wheeled toy should be the right size for the child – when sitting on the seat their feet should rest flat on the ground with the handlebars or steering wheel within reach.
- Keep a lookout for obstacles in the riding path.
- Be aware of the traffic flow.
- Inflate tires properly.
- Be a role model and wear a helmet when you ride.
- Remove the helmet when done riding – it could get caught in playground equipment.

Here is a reminder from the U.S. Consumer Product Safety Commission:

***Children should always wear helmets while riding their bikes. But when a child gets off the bike, take off the helmet. There is a "hidden hazard" of strangulation if a child wears a helmet while playing on playground equipment.***

## Burn prevention

Unintentional burn injuries can occur from fireplaces, appliances, grills, chemicals, electrical outlets, fires, hot water, and other hot liquids. More than one half of all burn center admissions for young children in Oklahoma are for a scald injury from hot water or other hot liquids such as coffee, tea and soup.

### Unintentional scalds can be prevented by following these tips:

- Set hot water heater thermostats between 100 and 120 degrees Fahrenheit.
- Always check the temperature of the water before placing a child in the bath.
- Keep hot beverages out of children’s reach.
- Never hold a child while drinking a hot beverage.
- When cooking, keep children out of the kitchen and place pan and pot handles toward the back of the stove where little hands cannot reach them.
- Allow food to cool slightly before serving to children.
- Supervise! Supervise! Supervise!

### Other burn prevention tips:

- Do not allow electrical cords to hang off counters or other surfaces; children may pull the appliance (and the hot food) onto themselves.
- Keep clothing irons, curling irons, and their cords out of reach of children.
- Keep children out of the midday sun and off hot surfaces.
- Keep children away from the grill when in use and until it has cooled completely.
- Test smoke alarms and practice fire drills and safely exiting the building each month.

## **Choking hazard safety**

A choking hazard is any object that could be caught in a child's throat blocking their airway and making it difficult or impossible to breathe.

**Food is a common choking hazard.** Foods commonly linked to childhood choking:

- Whole grapes
- Nuts and seeds
- Chunks of meat or cheese
- Hot dogs
- Chunks of peanut butter
- Raw vegetables
- Raisins
- Popcorn
- Chips
- Hard pretzels
- Hard or sticky candy
- Marshmallows
- Chewing gum

Cut food into small pieces that are NOT round in shape, enforce the rule that all children must remain seated while eating, and provide continual supervision.

**Common objects** that can be a choking hazard for children:

- Latex balloons
- Coins
- Marbles
- Button batteries
- Magnets
- Pen and marker caps
- Small balls
- Hair barrettes and beads
- Toys with small parts

Keep floors swept and continually monitor for small parts. Invest in a small parts tester, also called a "choke tube" to see which toys are too small for the children three years and younger.

**Always have staff on site with current certification in CPR and Airway Obstruction.**

## **Emergency preparedness**

As a child care provider, it is important that you prepare for all types of emergencies in order to keep children safe. Your best protection is knowledge and preparation. In addition to fire and tornado drills and preparing for medical emergencies, it is necessary to *develop an Emergency Plan* for a wide range of emergency situations.

*Your Emergency Plan should be in writing and include details about:*

- How you will account for each child's location during and after an emergency.
- How to handle situations after emergencies; such as damage to a structure with people still inside.
- What will happen after the emergency is over – how children will be reunited with their parents?
- Will you continue to take shelter until emergency crews arrive?

It's important to be careful not to slip into a routine when conducting drills. Each drill should be taken seriously every time it is done. Providers should also think outside the box when preparing to conduct drills and developing their Emergency Plan because emergencies are never routine. Conduct drills at different times of the day with all your staff members and prepare for “uncommon” emergencies like intruders or explosions not just the “more typical” fire and tornado emergency drills. For example, a situation threatening the safety of the children and personnel, such as shootings, hostages, or intruders would require a lock down procedure. Take special consideration for children with special needs and infants. Staff may need extra preparation when helping these children during an emergency.

*Conduct drills so that all staff members and children become familiar with the procedures.*

Prepare an emergency supply kit that all staff know about and take it on your practice drills. Provide information about your *Emergency Plan* to families whose children attend your child care program. As always, review your licensing requirements for specific instructions on what is needed in your emergency plan and talk with your licensing worker if you have any questions.

### **Types of emergencies to cover in your Emergency Plan**

- Abduction by non-custodial adult
- Fire
- Human threats such as bomb threats or hostage situations
- Injuries requiring medical or dental care
- Lost or missing child
- Natural disasters such as tornado, blizzard, flood, earthquake
- Poison exposure, including exposure to toxic substances
- Potentially violent situations in the program, including individuals with threatening behaviors
- Power failure or water failure
- Procedures for serious injuries and illnesses
- Reporting emergencies

**Ways caregivers and children can plan for and practice procedures for Emergency Preparedness:**

- Caregivers maintain current First Aid and CPR training.
- Children and caregivers practice drills and handling of all different types of emergencies.
- Children and caregivers know at least two exits from the rooms and the building.
- Caregivers have at least two evacuation location sites (one nearby, one farther away) and at least two ways to reach the alternate sites.
- Discuss your plans, evacuations, locations, and drills with staff members, children, and families.

**You can do all of these around the same time each year to ensure compliance with licensing requirements and keep your program safe and in order:**

- Emergency equipment and first aid kits are regularly tested and restocked or replaced.
- Review Emergency Plans with everyone.
- Update families' emergency information.

**Communicate your Emergency Plan:**

- Share your Emergency Plan with families upon enrollment and at least yearly thereafter.
- Help families update their personal information like phone numbers and emergency contacts at least yearly.
- Train staff at least yearly on your Emergency Plan.
- Give copies of all changes or updates in your Emergency Plan to staff members and families.
- Share your Emergency Plan with local emergency responders such as the fire department.

Emergency Plans will vary for each program. It is important to have a plan that is specific for your child care facility that all staff members are aware of. Some available tools and resources for developing your Emergency Plan are listed below.

- Federal Emergency Management Agency (FEMA) <http://www.ready.gov/>
- Centers for Disease Control and Prevention <http://www.cdc.gov/> (search "Emergency Preparedness")
- National Association of Child Care Resource and Referral Agencies <http://www.naccrra.org> (search *Emergency Preparedness*)
- Oklahoma Licensing Requirements for Child Care Facilities
- Sesame Street "Let's Get Ready" interactive guide for children, families, and staff. <http://www.sesamestreet.org/>

## Emergency supplies list

These items are needed at your child care program in case of evacuation or natural disaster. Place items in an easy-to-carry waterproof container. The supplies should be stocked to last 3-6 hours. This list should be adjusted to fit the specific needs of each child care program.

- \_\_\_ Battery powered radio (a weather radio is best)
  - \_\_\_ Battery powered flashlight for each staff member
  - \_\_\_ Extra batteries for flashlights and radio
  - \_\_\_ First Aid Kit
  - \_\_\_ List of emergency phone numbers and contacts for each child
  - \_\_\_ 6 hour supply of all baby food, including breast milk and formula \*
  - \_\_\_ Baby bottles
  - \_\_\_ Bottled water
  - \_\_\_ Plenty of snacks for children and staff
  - \_\_\_ All prescription medication for children and staff in attendance \*
  - \_\_\_ Paper cups, paper towels, paper plates, and plastic utensils
  - \_\_\_ Diapers, diaper wipes, and ointments for infants and children still in diapers
  - \_\_\_ Plastic trash bags
  - \_\_\_ Books, small toys, and games for the children
  - \_\_\_ Extra blankets, towels, sheets, clothes, etc.
  - \_\_\_ Any extra materials for children with special needs
- \*these items to be added when grabbing the kit for evacuation

## First Aid Kits

Readily available first aid kits should be maintained in the center or home, and an additional kit should be available when transporting children. The kits should always be inaccessible to children.

### First Aid Kits should contain

- non-medicated adhesive strips
- sterile gauze pads
- rolled flexible or stretch gauze
- bandage tape
- disposable non-porous, latex-free gloves
- blunt-tipped scissors
- tweezers
- thermometer that is non-glass and non-mercury
- a current first aid guide
- a copy of the posted program information and emergency numbers.
- The telephone number for the **Poison Control Center** should be written in or on the first aid kit. **1-800-222-1222**

In addition, **the first aid kits in vehicles** should include:

- a cold pack
- liquid soap and water or individually packaged moist, disposable towelettes, for cleaning wounds

- hand sanitizer and moist, disposable towelettes, for hand hygiene
- plastic bags for disposal of items contaminated with blood or other body fluids
- a pen or pencil and a note pad

Review your emergency supply kit and first aid kits often to discard and replace materials. Make sure staff members know the location of each kit.

## **Fall prevention**

Young children are independent, curious, and like to climb. They should be supervised at all times and kept off high surfaces to prevent fall injuries.

### **Infants**

- Never leave an infant alone on a counter, bed, table, couch, or other high place.
- Always keep at least one hand on the infant when changing diapers or dressing.
- An infant carrier should be stable and placed where the child and carrier can't fall.
- Lower the crib mattress as the child grows. If the child is climbing out of the crib, consider if it is time to move to a toddler bed.
- Keep safety straps securely fastened when using a stroller, high chair, swing, carrier, or shopping cart.
- Keep play area clear of hard, sharp-edged objects and toys.
- **Get rid of your baby walkers** if you haven't already. Walkers are involved in more injuries than any other piece of baby equipment.
- Don't let other children hold or carry an infant unless closely watched.

### **Young children**

- Install safety gates at the top and bottom of stairs and keep stairs free of clutter.
- Install window guards - screens keep bugs out, not children in.
- Keep windows locked when closed.
- Keep doors to balconies and fire escapes locked.
- Place outdoor equipment in a safe location.
- Outdoor play equipment such as swings, slides and climbing toys should be placed on impact absorbing surfaces such as wood chips or chipped rubber.
- Anchor all outdoor play equipment not designed to be portable.
- Playground equipment should be in good repair and age appropriate.
- Watch children closely when they are playing on slides, swings, and seesaws.
- Hold the child's hand while climbing stairs or riding escalators; teach the child to hold onto handrails to avoid falling.
- Bicycles should be in good repair and the correct size for the child.
- Never let your children ride a bicycle without a helmet. If the child is riding on a bicycle with an adult, the child should be in a rear-mounted seat and wearing a helmet.
- A child with a disability needs more attention and supervision to avoid falls.
- These safety precautions apply to child care and at home.

## **Infant Safe Sleep**

### **Reduce the risk of sudden infant death syndrome (SIDS) and other sleep-related causes of infant death**

Sudden Infant Death Syndrome is the sudden unexplained death of a baby younger than one year of age that doesn't have a known cause even after a complete investigation. SIDS is the leading cause of death in babies from 1 month to 1 year of age. Other sleep-related causes of infant death are those linked to how or where a baby sleeps or slept. They are due to accidental causes, such as; suffocation; entrapment when baby gets trapped between two objects, such as a mattress and a wall, and can't breathe; or strangulation, when something presses on or wraps around baby's neck, blocking baby's airway.

#### **To reduce infant deaths from SIDS, suffocation, or strangulation use the following strategies:**

- Always place baby on his or her back to sleep, for naps and at night.
- Use a firm sleep surface, such as a mattress in a safety-approved crib, covered by a fitted sheet.
- Keep soft objects, toys, and loose bedding out of baby's sleep area.
- Make sure nothing covers baby's head.
- Do not let baby get too hot during sleep. Dress baby in light sleep clothing, such as a one-piece sleeper, and keep the room at a comfortable temperature.
- Do not use pillows, blankets, sheepskins, or crib bumpers anywhere in baby's sleep area.
- Baby should not sleep in an adult bed, on a couch, or on a chair alone, with you, or with anyone else.
- Do not smoke or allow anyone to smoke around baby.
- Breastfeeding is recommended and is associated with a reduced risk of SIDS.
- Baby should be up-to-date on all immunizations.
- Never place a crib near a window with mini-blind or curtain cords, or near baby monitor cords; babies can strangle on cords.
- Remember tummy time! Place baby on his or her stomach while awake and someone is watching. Tummy time helps baby's head, neck and shoulder muscles develop.

#### **Always Back To Sleep**

The American Academy of Pediatrics (AAP) recommends placing all healthy babies to sleep on their backs in order to reduce the risk of SIDS and other sleep-related causes of infant death.

- Babies should be placed on their backs for both nighttime sleeping and naps.
- Babies placed on their backs are not at increased risk of choking. Babies naturally swallow or cough up fluids.
- Babies are less likely to re-breathe air during sleep while on their backs. There is more air space around baby's nose and mouth.

Props, wedges and positioning devices are not needed to keep babies in the back position, and are not tested or proven to be safe in the crib.

### **Safe sleep environment**

- Place each baby alone in a safety-approved crib or portable crib.
- The crib has a firm mattress with a well-fitted sheet.
- Toys and other soft bedding, including bumper pads, comforters, blankets, pillows, stuffed animals and wedges are not placed in infants' cribs.
- Keep baby's face uncovered. Babies are at an increased risk of dying if their head becomes covered during sleep.
- Keep the child care environment smoke-free. Exposure to secondhand smoke increases the risk for Sudden Infant Death Syndrome.
- Prevent babies from overheating. The infant room should be maintained at a comfortable temperature.
- Infants are **NOT** covered with a blanket. If additional warmth is needed, a one-piece blanket sleeper or an infant sleep sack may be used.
- Make sure everyone who cares for the infants knows to place them on their backs for sleep.

### **Promote infant safe sleep practices**

- Develop a written policy on infant sleep safety to share with parents when they enroll their child.
- Train all staff on Infant Safe Sleep practices.
- Distribute Infant Safe Sleep information to all staff and families.
- Display Infant Safe Sleep posters.
- Tell everyone caring for babies about Infant Safe Sleep practices.

### **Back to sleep, tummy to play**

Tummy time when babies are awake is important because:

- Play in this position strengthens the neck and trunk muscles needed for head control.
- This position also strengthens the shoulders, arm and hand muscles.
- Skills learned during tummy time enable an infant to move around and explore.
- Exploration leads to higher-level thinking and problem solving skills.
- Infants need time off the back of their heads to avoid a flattening appearance or uneven head shape.

Visit the Safe to Sleep Public Action Campaign: <http://www.nichd.nih.gov/sts/>.

## Motor vehicle safety

### Car safety seats and child passenger safety

According to the National Highway Traffic Safety Administration child safety seats decrease the risk of death in passenger crashes by 71% for infants and 54% for toddlers.

#### The **American Academy of Pediatrics** recommends:

- Children ride rear-facing in an infant carrier or convertible car seat from birth until the child reaches the height and weight specified by the child safety seat manufacturer.
- Children should remain rear-facing until they are 2 years of age.
- After your child has outgrown his/her rear-facing car seat, he/she may ride in a forward-facing seat (combination seat or booster seat).
- A forward-facing seat with an internal harness should be used until the child reaches the harness weight limit indicated by the manufacturer. The minimum weight is 40 pounds.
- Your child should ride in a belt-positioning booster until the vehicle seat belt fits correctly (usually around 8-9 years of age).
- A belt-positioning booster should always be secured with a seat belt, even when the child is not riding in it so it does not become a projectile in a crash.
- Seat belts are made for persons who are at least 4 feet, 9 inches tall, as long as the seat belt fits correctly.

#### When using a seat belt

- The shoulder belt should lie on the collar bone and across the middle of the chest.
- The lap belt should be snug and lie across the upper thighs/pelvic bones.
- The child should be able to sit with his/her back against the vehicle seat back with knees bent comfortably over the vehicle seat and feet on the floor.

Always refer to your car owner's manual and child safety seat manual for correct installation instructions, or have your seat installed or checked by a **Certified** Child Passenger Safety Technician.

### Common errors in child passenger safety

#### *Selection errors*

- Child does not meet weight and height requirements of safety seat.
- Child is too small or too young for safety seat.
- Safety seat is too old or the history of a safety seat is unknown.
- Safety seat has been involved in a moderate to severe crash.
- Safety seat is under current recall (check with your child safety seat manufacturer).

#### *Harness errors*

- Harness is not used.
- Harness straps are too loose.
- Harness straps are routed through the wrong slots or are secured incorrectly.
- Harness straps are placed on the child incorrectly.
- Harness straps are damaged or twisted.
- Retainer clip (chest clip) is too low.

### ***Installation errors***

- Safety seat is facing the wrong direction (based on child's age and weight).
- Recline angle of the safety seat is incorrect.
- Carrying handle of infant carrier is positioned incorrectly while vehicle is in motion.
- Safety seat should only be installed with safety belt **OR** lower anchors and tethers (LATCH), not both (unless specified by the car seat manufacturer).
- **NEVER** install a rear-facing child safety seat in front of an active airbag.

Front seat air bags may hurt children. Riding in the back seat of the vehicle is the safest way for children to travel.

Resources: Injury Prevention Service at OSDH, and Safe Kids Oklahoma

### **Heatstroke safety – kids in hot cars**

Kids in hot cars are a deadly combination. These deaths are preventable. Here are some tips to make sure it doesn't happen:

- **Never leave a child or children alone in a parked car**, even with the windows rolled down, or air conditioning on. Children's body temperature can heat up to 3 to 5 times faster than adults. A core temperature of 107 is lethal.
- Always look in the front and back of the vehicle before locking the doors and walking away.
- Always lock your vehicle doors and trunk and keep the keys out of children's reach. If a child is missing, quickly check all vehicles, including the trunk.
- Never let children play in an unattended vehicle. Teach them a vehicle is not a play area.
- Heatstroke can occur in temperatures as low as 57 degrees. On an 80 degree day, temperatures inside a vehicle can reach deadly levels in just 10 minutes.

If dropping your child off is not part of your normal routine come up with some ways to remind yourself that your child is in the car:

- Place an item that you take with you, like a purse or briefcase (or your left shoe) on the back seat next to the car seat so you'll check the back seat before you leave the car.
- Write a note and place it on the dashboard of the car.
- Set a reminder on your cell phone or calendar. You can also download the Baby Reminder App for iPhones.
- Ask your child care provider to call you if your child doesn't show up.

If you see a child alone in a hot vehicle call 911 or your local emergency number immediately!  
**Kids in hot cars are a deadly combination. Don't take the chance. Look before you lock!**

### **Resources**

National Highway Traffic Safety Administration - [www.safercar.gov/heatstroke](http://www.safercar.gov/heatstroke)

San Francisco State University, Department of Earth & Climate Studies

[www.ggweather.com/heat/](http://www.ggweather.com/heat/)

Safe Kids - [www.safekids.org](http://www.safekids.org)

Children's Hospital of Philadelphia – [www.chop.edu](http://www.chop.edu)

### **Poison prevention**

- Keep all medications and poisonous household products out of the reach of children and in their original containers.
- Try to reduce the number of cleaning products used and substitute nontoxic products for poisonous ones when possible.
- Check all children’s art supplies to make sure they are nontoxic.
- Some pet supplies are poisonous and must be stored as such – aquarium chemicals, flea sprays and pet medications.
- Move all dangerous items to a cabinet or closet a minimum of 4 feet above the floor, out of the reach of children, and install cabinet and drawer latches.
- Do not call medicine “candy”.
- Avoid taking medication in front of children.
- Never leave children alone with household products or drugs.
- Be sure all purses and backpacks are inaccessible to children.

### **Suffocation and strangulation prevention**

- Infants should never sleep on waterbeds, sofas, soft mattresses or other soft surfaces.
- Infants less than one year of age should not be on adult or youth beds.
- Plastic bags, including garbage and dry cleaning bags, should be kept out of the reach of children.
- Keep balloons, including uninflated balloons, out of the reach of young children. Immediately pick up and dispose of pieces of broken balloons.
- Tie up or clip off blind and drapery cords; keep cribs away from cords.
- Don’t hang anything with strings or ribbon over infant cribs.
- When feeding a child in a high chair, use the safety straps, including the crotch strap. This will prevent the child from slipping down, which could cause serious injury or even death.

- Avoid the use of hoods with drawstrings in the clothing of young children. The drawstrings could catch on something and strangle a child.
- Remove bike helmets when done riding bikes or riding toys.
- Never attach ropes, clotheslines, or pet leashes to playground equipment because children can strangle on them.

### **Sun safety**

Prolonged exposure to sun, repeated sunburn, and even one severe sunburn may lead to skin cancer later in life.

- Keep babies younger than 6 months out of direct sunlight. Find shade under a tree, an umbrella, or the stroller canopy.
- In the hottest part of the summer, children should do most of their outdoor play before 10:00 A.M. and after 3:00 P.M.
- All outdoor playgrounds should have shaded areas.
- Children over six months of age should use sunscreen with an SPF of at least 30 and it should be applied 30 minutes before going outside.
- Reapply sunscreen every 30 minutes, even on cloudy days.
- Sunscreen should not be used on children under six months of age because the chemicals may be too strong for their skin.
- Wear lightweight, loose-fitting clothing in the sun.
- Receive parents' written permission to apply sunscreen to their children. (This can be done using the same permission form for medication).

### **Water safety**

Children less than five years of age have the highest rate of drowning and near drowning of all age groups. **Children can drown in just a few seconds.**

- Always stay close and watch children when they are in or near water. Be sure there are adequate personnel during water play and when taking the children swimming.
- Constantly supervise children involved in water play or in a bathtub.
- No standing water! Check for standing water on the playground after a rain.

- Keep toilet lids down and empty buckets and containers immediately after use.
- Never take a child swimming if his/her parents have not given written consent.
- Never take children to a pool that does not have trained lifeguards on duty.
- Completely surround swimming pools with childproof fences and keep gates locked.

**Weapons and ammunition safety**

Keep all weapons and ammunition, such as firearms, cap pistols, bows and arrows, and hunting knives, in an inaccessible area. In addition:

- Weapons are kept unloaded in locked containers or cabinets.
- Ammunition is kept in locked containers or cabinets, separate from weapons.
- Keys, combinations, and codes used for locked storage are inaccessible.
- Parents are informed of weapons upon enrollment.

## Infection Control

Many infectious diseases can be prevented by following these simple steps:

1. **Wash Hands Often!** Hand washing is the most important way to reduce the spread of infection. All staff, volunteers, and children should wash hands at the following times:
  - a. Upon arrival for the day, after breaks, or when moving from one child care group to another.
  - b. Before and after:
    - Preparing food or beverages
    - Eating, handling food, or feeding children
    - Giving medications or applying a medical ointment or cream
    - Playing in water that is used by more than one person
    - Diapering
  - c. After:
    - Using the toilet or helping a child use a toilet
    - Handling bodily fluid (mucus, blood, vomit), from sneezing, wiping and blowing noses, from mouths, or from sores
    - Handling animals and cleaning up animal waste
    - Playing in sand, on wooden play sets, and outdoors
    - Cleaning and handling the garbage

### 1. Routinely clean, sanitize, and disinfect surfaces.

Programs should follow a routine schedule of cleaning, sanitizing, and disinfecting. Cleaning, sanitizing, and disinfecting products should not be used in close proximity to children, and adequate ventilation is needed during use.

We sometimes use these terms interchangeably, but they are not the same. Here is how the United States Environmental Protection Agency (EPA) defines them:

*To clean* means to physically remove dirt and debris from the surface by scrubbing, washing, wiping, and rinsing. This can be done with water and a mild soap or detergent.

*To sanitize* means to apply a product that reduces germs to safer levels. Sanitizing surfaces destroys enough germs to reduce the risk of becoming ill from contact with those surfaces. Sanitizing is recommended for food surfaces (dishes, utensils, cutting boards, high chair trays) and other objects intended for the mouth like pacifiers and teething toys.

*To disinfect* means to apply a product that destroys nearly all germs when applied to hard, nonporous surfaces. Disinfecting is a higher level of germ killing and is recommended for hard nonporous surfaces such as toilets, changing tables, and other bathroom surfaces; blood spills and other potentially infectious body fluids like vomit, urine and feces.

### 2. Get immunized.

Keep records of all immunizations for the children and the staff.

### 3. Keep pets healthy.

All pets should be routinely cared for by a veterinarian.

### 4. Handle and prepare food safely.

- Plan carefully when purchasing your food. Buy perishable foods, such as dairy products or fresh meat, at the end of your shopping trip. Refrigerate as soon as possible.
- Store food properly. Don't allow juices from meat, seafood, poultry, or eggs, to drip on other foods. Use containers to keep these products from contaminating other foods. Don't leave perishable food out for more than 2 hours.
- Use care when preparing and cooking food. Wash your hands and clean and disinfect all kitchen surfaces and utensils before, during, and after handling, cooking, and serving food. Wash raw fruits and vegetables. Avoid eating raw eggs or partially cooked eggs. Cook all poultry and meat until the juices run clear. Use different dishes and utensils for raw foods and cooked foods. Keep cold foods cold and hot foods hot.
- Store leftovers properly. Avoid leaving leftovers out for more than 2 hours. Promptly refrigerate or freeze perishable items.

### Appropriate antibiotic use

Antibiotics only cure bacterial infections, not viral infections such as:

- Colds or flu
- Most coughs and bronchitis
- Sore throats not caused by strep
- Many ear infections
- Runny noses

**What is appropriate antibiotic use?** Antibiotics are strong medicine, and need to be taken correctly. This means:

1. Taking antibiotics exactly as prescribed.
2. Always finishing an antibiotic prescription, even if you feel better.
3. If you are taking an antibiotic and you do not feel better within a couple of days, report to your healthcare provider.
4. Do not pressure your healthcare provider to prescribe an antibiotic for you. Some illnesses such as viral or minor infections should not be treated with antibiotics.
5. Never take an antibiotic that was prescribed for someone else, or was left over from a previous infection.

**What is the risk when antibiotics are not taken correctly?** Bacteria can change and become resistant to antibiotics when they are not taken correctly. Infections caused by antibiotic-resistant bacteria can be more difficult to treat. Sometimes antibiotic-resistant infections can only be treated with intravenous (IV) antibiotics which must be given in a healthcare facility.

**What is antibiotic-resistance?** Antibiotic resistance happens when bacteria become able to resist the effects of agents such as antibiotics that could usually cure the infection.

**Are antibiotic-resistant infections spread more easily?** No, they are spread in the same ways as non-resistant infections, and also prevented in the same ways.

### **Communicable disease**

A communicable disease is an illness that can be transmitted or spread from one person or animal to another.

Three factors are required for this to occur:

- A pathogen – a disease-causing agent such as a bacteria, virus, or parasite.
- A susceptible host – a person who can become infected with the pathogen.
- A method of transmission – a route for the infectious agent to go from the original source to another host.

Germs are living species that are invisible without a microscope and may cause illness. Once germs leave the body through coughs, sneezes, saliva, blood, bowel movements or urination, they die unless they find their way into another human body.

Common methods of transmitting disease

- Airborne transmission
- Fecal-oral transmission
- Direct contact
- Indirect contact

**Cover your cough: cough etiquette** (*See Appendix for Cover Your Cough Poster*)

Many serious illnesses such as influenza (flu), respiratory syncytial virus (RSV), and whooping cough are spread by coughing, sneezing, or unclean hands.

**What is it?** Help stop the spread of germs that can make you and others sick by covering your mouth when you cough or sneeze. Staff members should teach children the importance of “*covering your cough*” and set an example for them.

### **What should be done?**

- Cover your mouth and nose with a tissue when you cough or sneeze.
- Put your used tissue in the waste basket.
- If you don't have a tissue, cough or sneeze into your upper sleeve or elbow.
- After using a tissue, wash your hands with soap and warm water for 20 seconds.
  - If soap and water are not available, use an alcohol-based hand rub.
- DO NOT cough or sneeze into your hands. Your hands will then spread germs to everything you touch.
  - But if you forget, just wash your hands with soap and water immediately.

## Decrease the spread of disease

There are many ways to decrease the spread of disease in a child care setting:

- **WASH HANDS OFTEN!** Use soap and water when washing hands and dry with a paper towel.
- Prevent germs from spreading to others by teaching children to cover their mouth and nose with a tissue or their upper sleeve when coughing or sneezing. Dispose of tissues immediately and have children wash their hands.
- Use individual tissues for wiping and blowing noses. Dispose of tissues immediately into a covered waste container and wash hands before touching anything else.
- Keep surfaces, toys and equipment clean and sanitized.
- Require children to keep immunizations up to date.
- Urge everyone to get a flu vaccine.
- Prepare and handle food safely.

## Outbreaks of illness

**What is it?** An **outbreak**, also called a **cluster**, happens when the number of people with the same symptoms is higher than normally expected. This might just be a “hunch”, so pay attention to that feeling and follow the steps below to stop the spread.

### 1. Limit exposures.

- A. Remove children and employees with symptoms of illness from contact with others. Supervise children until their parent or appropriate adult arrives to take them home.
- B. Clean hands are very important: Because most illnesses are spread on unclean hands, remind all children and employees to wash their hands frequently using soap and water or alcohol-based hand products. Be sure these items are adequately stocked. Employees may need to wear gloves, so be sure these are available as well.
- C. Cover your cough: Because fluids from coughs and sneezes contain germs, remind children and employees to use a tissue to cover their noses and mouths when coughing or sneezing, then immediately throw it away, and wash their hands. Encourage people to cough into their sleeve when a tissue isn't readily available. Employees who assist children with nose-blowing should wash their hands immediately afterwards.

**2. Call the health department as soon as possible.** The Acute Disease Service of the Oklahoma State Department of Health has an epidemiologist on call 24 hours a day, 7 days a week, all year long to work with you. The number is 405-271-4060. You may need to leave a message, but your call will be returned shortly.

**3. Start a list of the ill persons.** This is also called a line list. The health department can send you a blank form if needed. The information on the form will include each person's age, classroom, symptoms, and date they became ill. Remember to include employees on the list.

**4. Be ready to provide as much of this information as you can when you call the health department:**

- A. The total number of people in your program by group (employees, attendees, other).
- B. The total number of people who are ill by each group.
- C. If anyone has been seen by a healthcare provider, and their name (if known).
- D. If any lab tests were done (if known), and if so, the name of the hospital or healthcare provider (if known).
- E. If anyone has been hospitalized, and if so, when and where.

**5. Additional information that may be needed, depending on the illness and your setting:**

- A. Menus for meals served during the two weeks before the first illness.
- B. A floor plan of your facility.
- C. Numbers of people by group and their vaccination records.

Taking these steps early can help prevent a larger outbreak, and protect other children and employees.

**Proper diapering procedures** (*See Appendix for Diapering Poster*)

1. Have diapering area ready before bringing the child to the area. Supplies need to be within reach and include a clean diaper, wipes, a plastic bag for soiled clothes, and a plastic-lined, hands-free, covered trash container.
2. Cover the diapering surface with disposable paper and put on disposable gloves.
3. Place the child on the diapering table and remove bottom clothes and any soiled clothing. **ALWAYS KEEP ONE HAND ON THE CHILD!**
4. Unfasten the diaper and clean the child's diaper area. With the soiled diaper under the child, lift the child's legs to clean the child's bottom. Clean from front to back with a fresh wipe each time.
5. Put soiled wipes in the soiled diaper. Remove the diaper and dispose of in in a plastic-lined, hands-free, covered can. If the disposable paper is soiled, use the paper that extends under the child's feet to fold up under the child's bottom. Remove gloves and dispose of them in hands-free can.
6. Use a fresh wipe to clean your hands. Use a fresh wipe to clean the child's hands.
7. Put a clean diaper under the child. Apply diaper cream with a tissue if needed. Fasten the diaper and dress the child.
8. Wash the child's hands. Place the child at the sink, moisten the child's hands, apply liquid soap and help rub, rinse with running water, then dry with a single use towel.
9. Return the child to a supervised area away from the diapering table.
10. Clean and disinfect the diaper changing area: discard the paper liner, remove visible soil with soap and water, apply EPA-registered disinfectant and use according to instructions. Be sure to leave the disinfectant on the surface for the required contact time.
11. Wash your hands with soap and running water.
12. Record the diaper change in the child's daily log. Include the time of diaper change and the contents. Note any problems such as skin redness, rashes, or loose stool.

## Diaper rash

### What is diaper rash?

Diaper rash can be any rash that develops inside the diaper area. In mild cases, the skin might be red. In more severe cases, there may be painful open sores. Diaper rash is usually seen around the abdomen, genitalia, and inside the skin folds of the thighs and buttocks. Mild cases clear up within 3 to 4 days without any treatment. If a rash persists or develops again after treatment, consult provider.

### What causes diaper rash?

Medical experts believe diaper rash is caused by too much moisture, chaffing and rubbing, prolonged contact of the skin with chemical irritants (feces, urine, detergents, etc.), which become trapped in the diaper area and cause irritation, yeast infection, bacterial infection and allergic reaction to diaper material.

When skin stays wet for too long, the layers that protect it start to break down. When wet skin is rubbed, it also damages easily. Moisture from a soiled diaper can harm baby's skin and make it more prone to chafing. When this happens, a diaper rash may develop. Further rubbing between the moist folds of the skin only makes the rash worse. This is why diaper rash often forms in the skin folds of the groin and upper thighs.

Babies taking antibiotics or nursing babies whose mothers are taking antibiotics are more likely to get diaper rashes caused by yeast infections. Yeast infects the weakened skin and causes a bright red rash with red spots at its edges. These can be treated with over-the-counter antifungal medications. If symptoms persist, contact provider.

### What should be done?

- Change wet or soiled diapers often.
- Use clear water from a squirt bottle to cleanse the diaper area – it lets you clean and rinse without rubbing.
- Pat dry; do not rub. Allow the area to air dry fully.
- Use creams or ointments with *written parental permission*.
- If the rash worsens or does not improve after four or five days of treatment, or if blisters or pus-filled sores are present, and/or if the child has a fever of 100.4 degrees or higher, **notify parents to seek medical attention**.

### What can be done to prevent diaper rash?

- Change diapers frequently.
- Do not put the diaper on airtight. Keep the diaper loose enough to prevent wet and soiled parts from rubbing against the skin so much.
- Gently clean the diaper area with clear water and pat the skin dry.
- Allow the skin to air dry for a few minutes before diapering.
- Apply a thin layer of a protective ointment or cream – *after obtaining written parental permission*.
- Do not use powders or cornstarch.

### **Proper hand washing procedures** (*See Appendix for Hand Washing Poster*)

Adults and children should wash their hands:

- Upon arrival for the day, after breaks, when moving from one child care group to another, and when leaving for the day.

Before and after:

- Preparing food or beverages
- Eating, handling food, or feeding a child
- Giving medication or applying a medical ointment of cream
- Playing in water that is used by more than one person, and playing with play dough

After:

- Using the toilet or helping a child use a toilet
- Diapering
- Handling body fluid from sneezing, wiping and blowing noses, from mouths, or from sores. Remember to wear disposable gloves when treating a bloody injury.
- Handling animals or cleaning up animal waste
- Playing in sand, on wooden play sets, and outdoors
- Cleaning and handling the garbage

### **How to wash hands:**

1. Moisten hands with warm running water and use liquid soap.
2. Rub hands together front, back, wrists, and between fingers for at least 10-20 seconds. (Sing two verses of Twinkle Twinkle, or a favorite hand washing song).
3. Rinse wrists to fingertips until free of soap under warm running water.
4. Dry hands with paper towel.
5. Use paper towel to turn off faucets and dispose of towel in a lined hands-free trash container.

### **Alternative Method for heavy infant or child unable to stand at sink:**

Here is an alternative method to washing the hands of an infant or toddler at the sink if they are too heavy to hold or have a special need that prevents standing at the sink. Use the “three paper towel” method as follows:

1. Wipe the child’s hands with a damp paper towel moistened with a drop of liquid soap.
2. Wipe the child’s hands with a 2nd paper towel wet with clear water.
3. Dry the child’s hands with a 3rd paper towel.
4. Discard used paper towels in a lined, hands-free trash container.

### **Universal (Standard) Precautions**

**What is this?** Universal Precautions are the use of hand hygiene, gloves, and any other method to protect contact with a body fluid that could make you sick. The idea is that you cannot tell from looking at someone whether they may have germs that could make you sick. Therefore, you need to always protect yourself.

## What should be done?

### Hand washing

- After diapering or toileting children
- After handling body fluids of any kind
- Before and after giving first aid (such as cleaning cuts and scratches or bloody noses)
- After cleaning up spills or objects contaminated with body fluids
- Right after you remove gloves

### Clean single-use disposable gloves should be worn

- During contact with blood or body fluids which contain blood (such as vomit or feces which contain blood you can see)
- When individuals have cuts, scratches or rashes which cause breaks in the skin of their hands

### When wearing gloves, remember:

- The gloves get contaminated, so do not spread germs by touching anything else.
- Remove gloves right after you've finished the task for which you wore them.
- Always wash your hands immediately after removing gloves.

**Why?** Because tiny holes were found in up to 50% of gloves after they were worn. You want to remove any germs that may have slipped in on your hands.

### Other important processes included in Universal Precautions:

- Cleaning all toys and surfaces with a bleach and water solution mixed daily. Clean at least daily, more often when soiled.
- Cleaning all diapering areas with a bleach and water solution. Clean after each use.
- Place any clothes or items that are soaked or caked with blood in to a plastic bag, tie it, then place that into another plastic bag and tie it. Send them home for washing.
- Sharps such as lancets for fingersticks, or syringes for injections given by parents must be placed in a special container for safe disposal. Ask the parent for a Sharps Container to safely store these sharps until the parent can take them home for disposal.
- Hepatitis B vaccination is recommended for all workers. This is a three-dose series. Per OSHA standards, the first dose should be given within 10 days of beginning employment, or within 24 hours after a potential blood exposure.
- Educate workers to report any contact with blood on their broken skin (cuts, scratches, open rashes or chapped skin) or on their mucous membranes (in the eye, mouth or nose).
- Keep records of documentation for every exposure situation, including if the worker was seen by a healthcare provider, and was offered the hepatitis B vaccination if she/he did not already have the series.
- Train all workers regarding Universal Precautions procedures upon employment.

See [www.osha.gov](http://www.osha.gov) for more information about Universal Precautions.

**UPDATED BLEACH/WATER CONCENTRATION INFORMATION**

**For 8.25% strength bleach concentration:**

<b>Sanitize (10 PPM)</b>	<b>Disinfect (600 PPM)</b>	<b>Special Clean-up (5000 PPM)</b>
<b>CLEAN &amp; SANITIZE AFTER EACH USE:</b> <ul style="list-style-type: none"> <li>Children’s mouthed toys</li> <li>Food service areas, dishes</li> </ul>	<b>CLEAN &amp; DISINFECT AFTER EACH USE:</b> <ul style="list-style-type: none"> <li>Diaper changing surface</li> </ul>	<b>CLEAN &amp; USE AS NEEDED FOR VOMIT AND DIARRHEA:</b> <ul style="list-style-type: none"> <li>Not for other bodily fluids</li> </ul>
<b>SANITIZE DAILY OR MORE OFTEN WHEN SOILED:</b> <ul style="list-style-type: none"> <li>Dishcloths, synthetic sponges</li> <li>Common surfaces (other than in bathrooms), floors, mats, tables, countertops and hard surfaces, doorknobs, etc.</li> </ul>	<b>DISINFECT DAILY OR MORE OFTEN WHEN SOILED:</b> <ul style="list-style-type: none"> <li>Bathroom areas</li> </ul>	<b>MIX SOLUTION WHEN NEEDED, THEN DISCARD</b> <ul style="list-style-type: none"> <li>WEAR GLOVES AND MASK TO PROTECT YOURSELF</li> </ul>
<b>1/8 teaspoon bleach/pint of water</b>	<b>3/4 teaspoon bleach/pint of water</b>	<b>2 tablespoons bleach/pint of water</b>
<b>1/4 teaspoon bleach/quart of water</b>	<b>1½ teaspoons bleach/quart of water</b>	<b>4 tablespoons bleach/quart of water</b>
<b>1 teaspoon bleach/gallon of water</b>	<b>2 tablespoons bleach/gallon of water</b>	<b>1 cup (8 oz.) bleach/gallon of water</b>

**And for 5.25% strength bleach concentration (if you can find it):**

<b>Sanitize (10 PPM)</b>	<b>Disinfect (600 PPM)</b>	<b>Special Clean-up (5000 PPM)</b>
<b>CLEAN &amp; SANITIZE AFTER EACH USE:</b> <ul style="list-style-type: none"> <li>Children’s mouthed toys</li> <li>Food service areas, dishes</li> </ul>	<b>CLEAN &amp; DISINFECT AFTER EACH USE:</b> <ul style="list-style-type: none"> <li>Diaper changing surface</li> </ul>	<b>CLEAN &amp; USE AS NEEDED FOR VOMIT AND DIARRHEA:</b> <ul style="list-style-type: none"> <li>Not for other bodily fluids</li> </ul>
<b>SANITIZE DAILY OR MORE OFTEN WHEN SOILED:</b> <ul style="list-style-type: none"> <li>Dishcloths, synthetic sponges</li> <li>Common surfaces (other than in bathrooms), floors, mats, tables, countertops and hard surfaces, doorknobs, etc.</li> </ul>	<b>DISINFECT DAILY OR MORE OFTEN WHEN SOILED:</b> <ul style="list-style-type: none"> <li>Bathroom areas</li> </ul>	<b>MIX SOLUTION WHEN NEEDED, THEN DISCARD</b> <ul style="list-style-type: none"> <li>WEAR GLOVES AND MASK TO PROTECT YOURSELF</li> </ul>
<b>1/8 teaspoon bleach/pint of water</b>	<b>1¼ teaspoons bleach/pint of water</b>	<b>3 tablespoons bleach/pint of water</b>
<b>1/4 teaspoon bleach/quart of water</b>	<b>1 tablespoon bleach/quart of water</b>	<b>6 tablespoons bleach/quart of water</b>
<b>1 teaspoon bleach/gallon of water</b>	<b>¼ cup bleach/gallon of water</b>	<b>1 ½ cup bleach/gallon of water</b>



# Chapter 6:

## Guidelines for Childhood Injuries

*We are using the algorithms from the Oklahoma Emergency Guidelines for Schools.*





## Chapter 6: Guidelines for Childhood Injuries

*We are using the algorithms from the Oklahoma Emergency Guidelines for Schools.*

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Ticks	p. 215
Unconsciousness	p. 216
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## ABOUT THE GUIDELINES

The emergency guidelines are meant to serve as basic “what to do in an emergency” information for child care providers without medical/nursing training. **It is strongly recommended that staff who are in a position to provide first-aid to children complete an approved first-aid and CPR course. In order to perform CPR safely and effectively, skills should be practiced in the presence of a trained instructor.**

The guidelines have been created as **recommended** procedures for when advanced medically trained personnel are not available on site. It is not the intent of these guidelines to supersede or make invalid any laws or rules established by the Department of Human Services (DHS), Child Care Services. Please consult DHS Child Care Services if you have any questions concerning the recommendations contained in the guidelines. In a true emergency situation, use your best judgment.

Please take some time to familiarize yourself with the format and review the "How to Use the Guidelines" section prior to an emergency situation.

The Oklahoma State Department of Health has reproduced these guidelines with the permission of the Ohio Department of Public Safety.

Special thanks go to the following individuals from the Ohio Department of Public Safety for their outstanding contributions to the development and preparation of the *Emergency Guidelines for Schools* (EGS):

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## HOW TO USE THE EMERGENCY GUIDE

In an emergency, refer first to the guideline for treating the most severe symptom (e.g., unconsciousness, bleeding, etc.).

- Learn when EMS (Emergency Medical Services) should be contacted. Copy the **When to Call EMS** page and post in key locations.
- The guidelines are arranged in **alphabetical order** for quick access.
- When the guidelines refer to school policies, you are to refer to the Oklahoma Licensing Requirements for child care programs, and any policies related to medical emergencies developed by the child care program.
- When the guidelines refer to student(s) they are referring to children attending the child care program.
- When the guidelines refer to responsible school authority they are referring to the child care director, family child care primary caregiver, or DHS Child Care Services.

# WHEN TO CALL EMERGENCY MEDICAL SERVICES (EMS) 9-1-1

## Call EMS if:

- The child is unconscious, semi-conscious or unusually confused.
- The child's airway is blocked.
- The child is not breathing.
- The child is having difficulty breathing, shortness of breath or is choking.
- The child has no pulse.
- The child has bleeding that won't stop.
- The child is coughing up or vomiting blood.
- The child has been poisoned.
- The child has a seizure for the first time or a seizure that lasts more than five minutes.
- The child has injuries to the neck or back.
- The child has sudden, severe pain anywhere in the body.
- The child's condition is limb-threatening (for example, severe eye injuries, amputations or other injuries that may leave the child permanently disabled unless he or she receives immediate care).
- The child's condition could worsen or become life-threatening on the way to the hospital.
- Moving the child could cause further injury.
- The child needs the skills or equipment of paramedics or emergency medical technicians.
- Distance or traffic conditions would cause a delay in getting the child to the hospital.



**If any of the above conditions exist, or if you are not sure, it is best to call EMS 9-1-1.**



# ALLERGIC REACTION

Students with life-threatening allergies should be known to appropriate school staff. An emergency care plan should be developed. Staff in a position to administer approved medications should receive instruction.

Children may experience a delayed allergic reaction up to **2 hours** following food ingestion, bee sting, etc.

Does the student have any symptoms of a severe allergic reaction which may include:

- Flushed face?
- Dizziness?
- Seizures?
- Confusion?
- Weakness?
- Paleness?
- Hives all over body?
- Blueness around mouth, eyes?
- Difficulty breathing?
- Drooling or difficulty swallowing?
- Loss of consciousness?

NO

Symptoms of a mild allergic reaction include:

- Red, watery eyes.
- Itchy, sneezing, runny nose.
- Hives or rash on one area.

YES

- Check student's airway.
- Look, listen and feel for breathing.
- **If student stops breathing, start CPR. See "CPR."**

Adult(s) supervising student during normal activities should be aware of the student's exposure and should watch for any delayed symptoms of a severe allergic reaction (see above) for up to 2 hours.

Does student have an emergency care plan available?

NO

Follow school policies for students with severe allergic reactions. Continue CPR if needed.

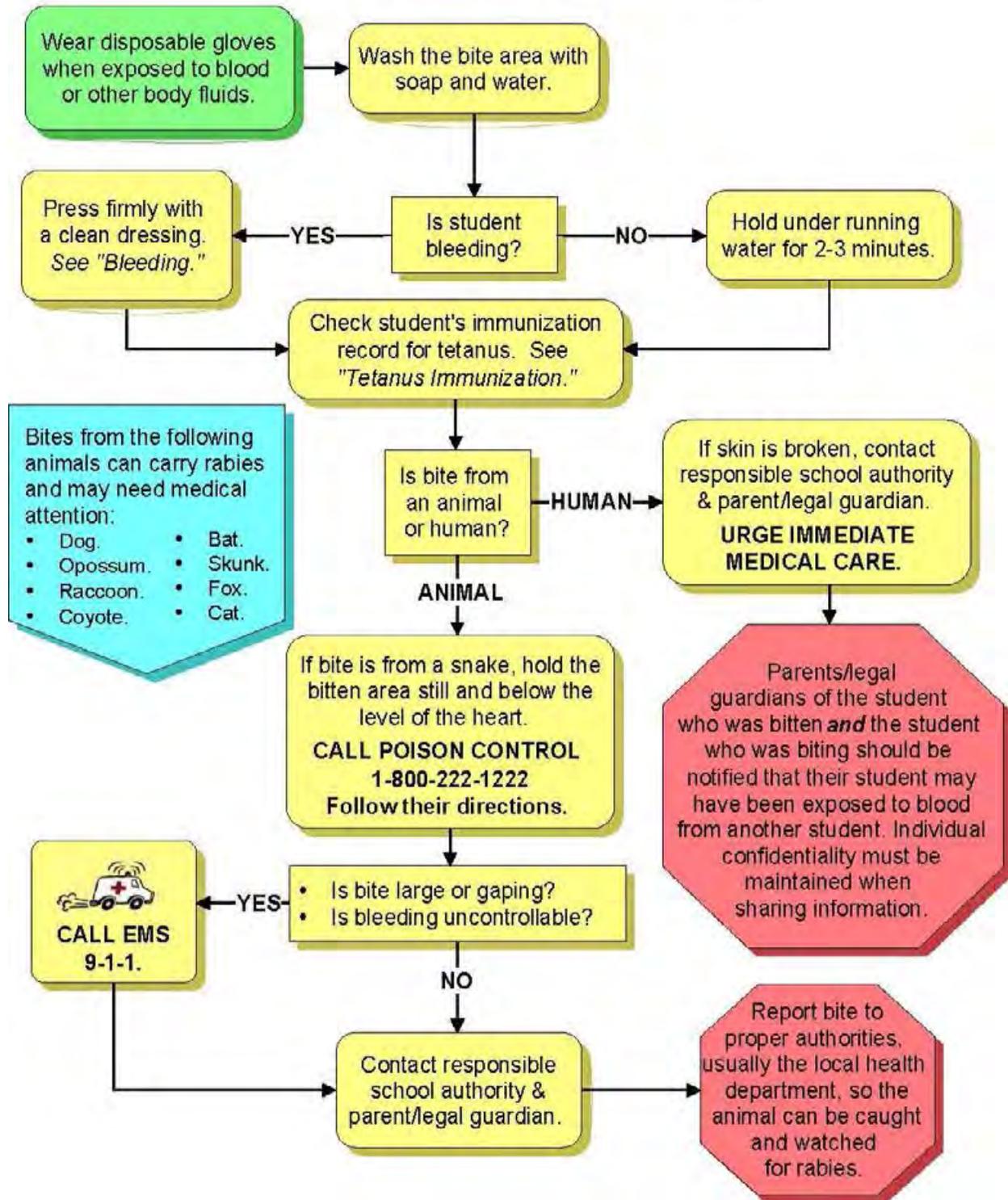
YES

Refer to student's plan. Administer doctor- and parent/guardian-approved medication as indicated.

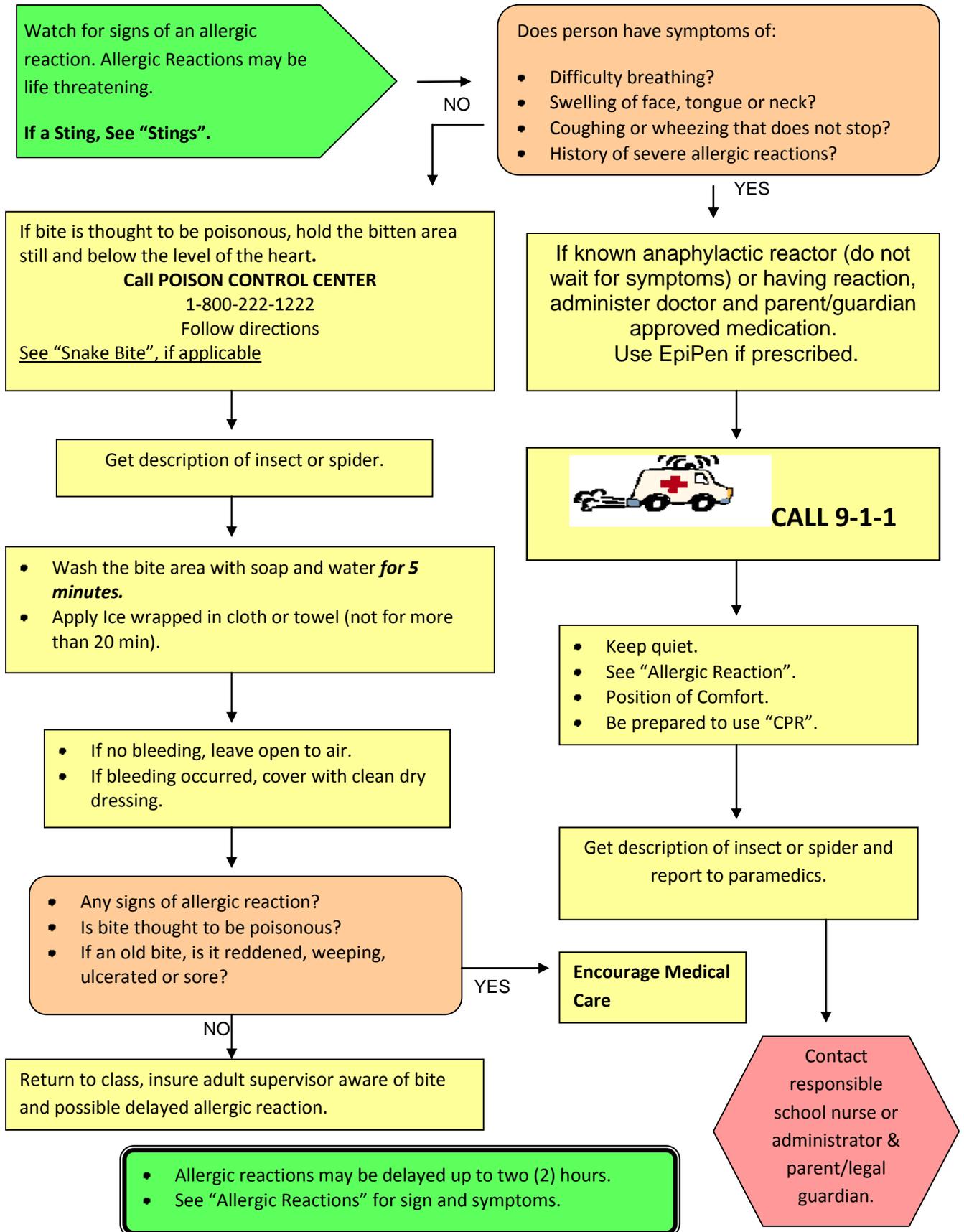
If student is so uncomfortable that he/she is unable to participate in school activities, contact responsible school authority & parent or legal guardian.

 **CALL EMS 9-1-1.**  
Contact responsible school authority & parent or legal guardian.

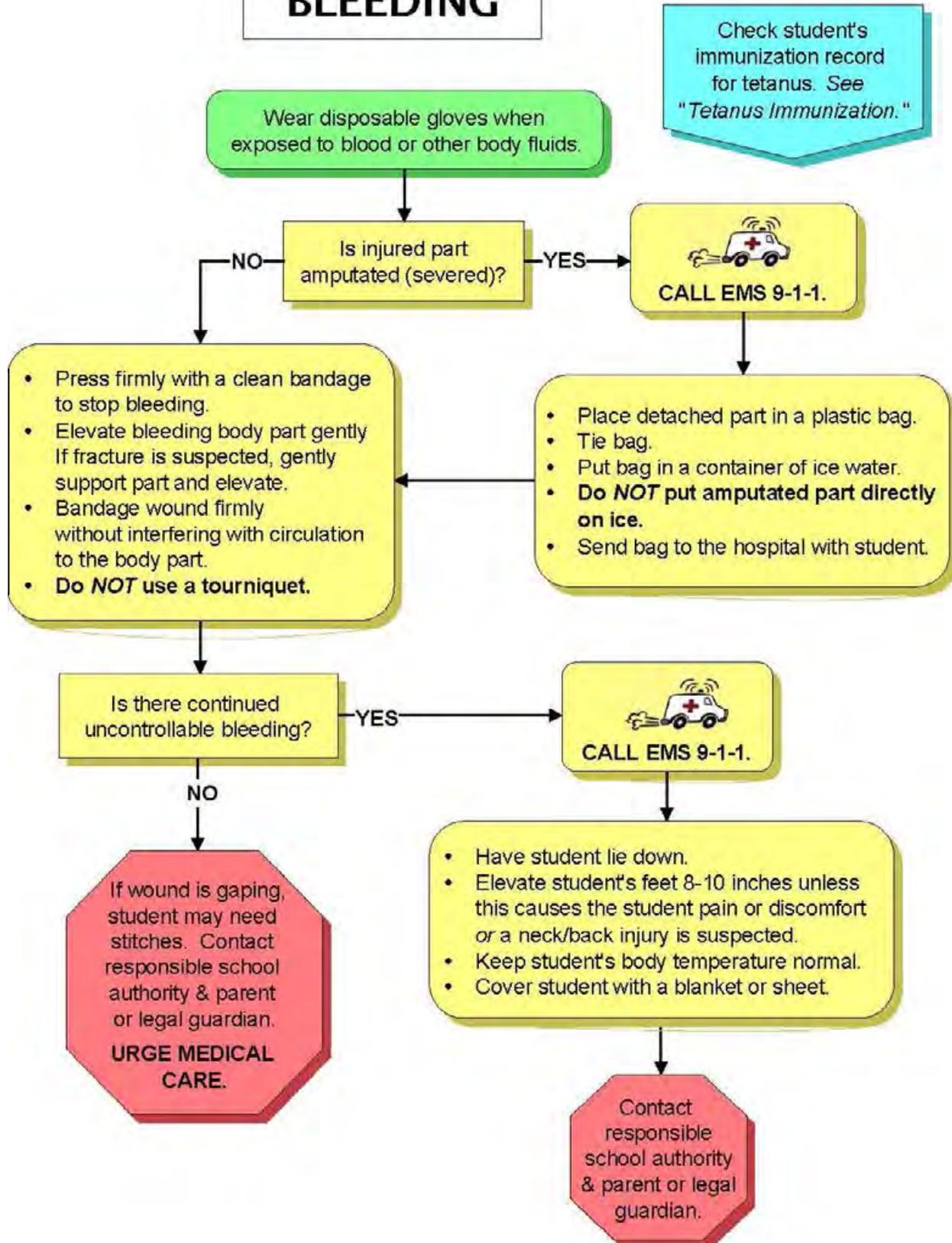
# BITES (HUMAN & ANIMAL)



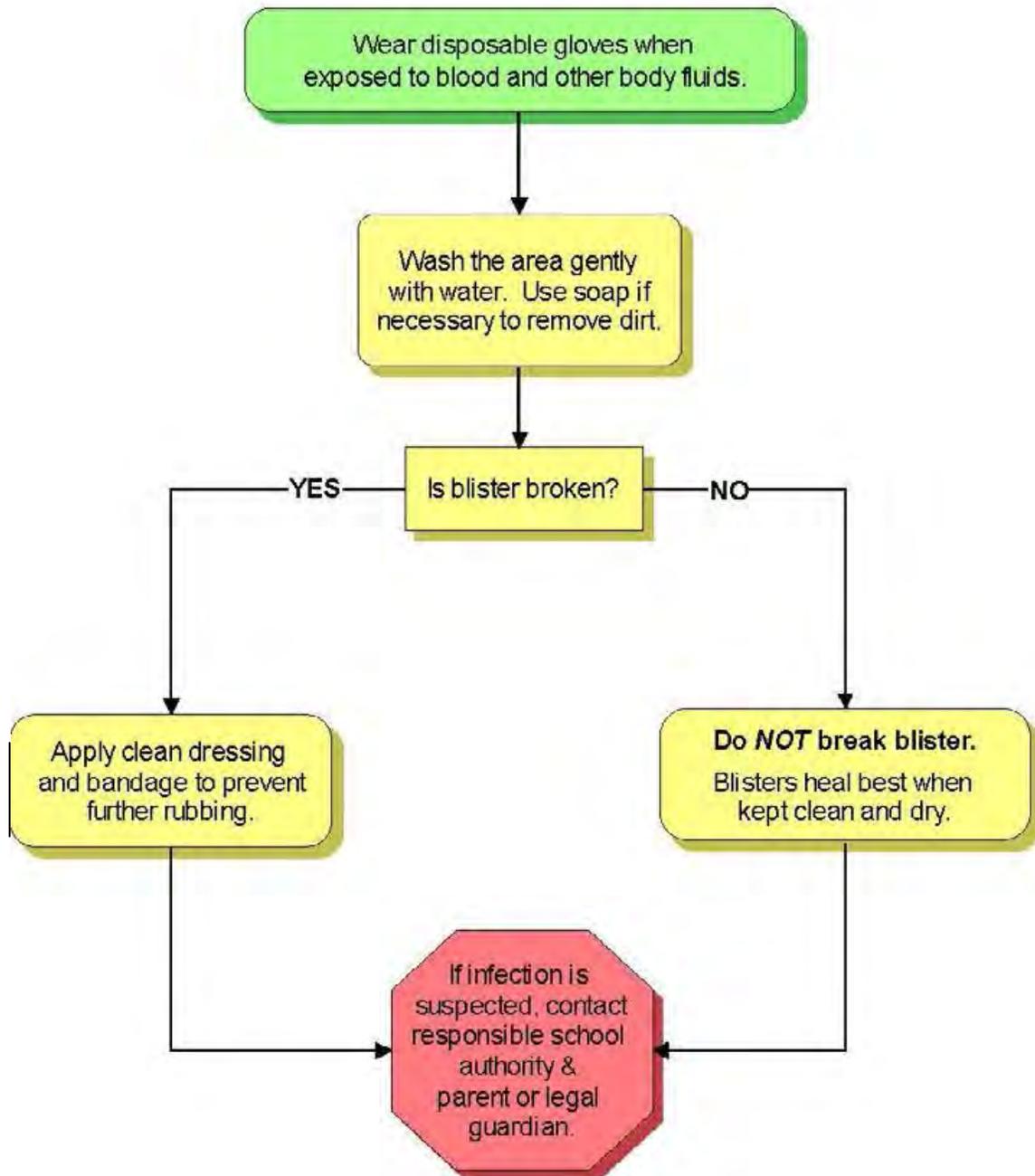
# BITES (Insect & Spider)



# BLEEDING

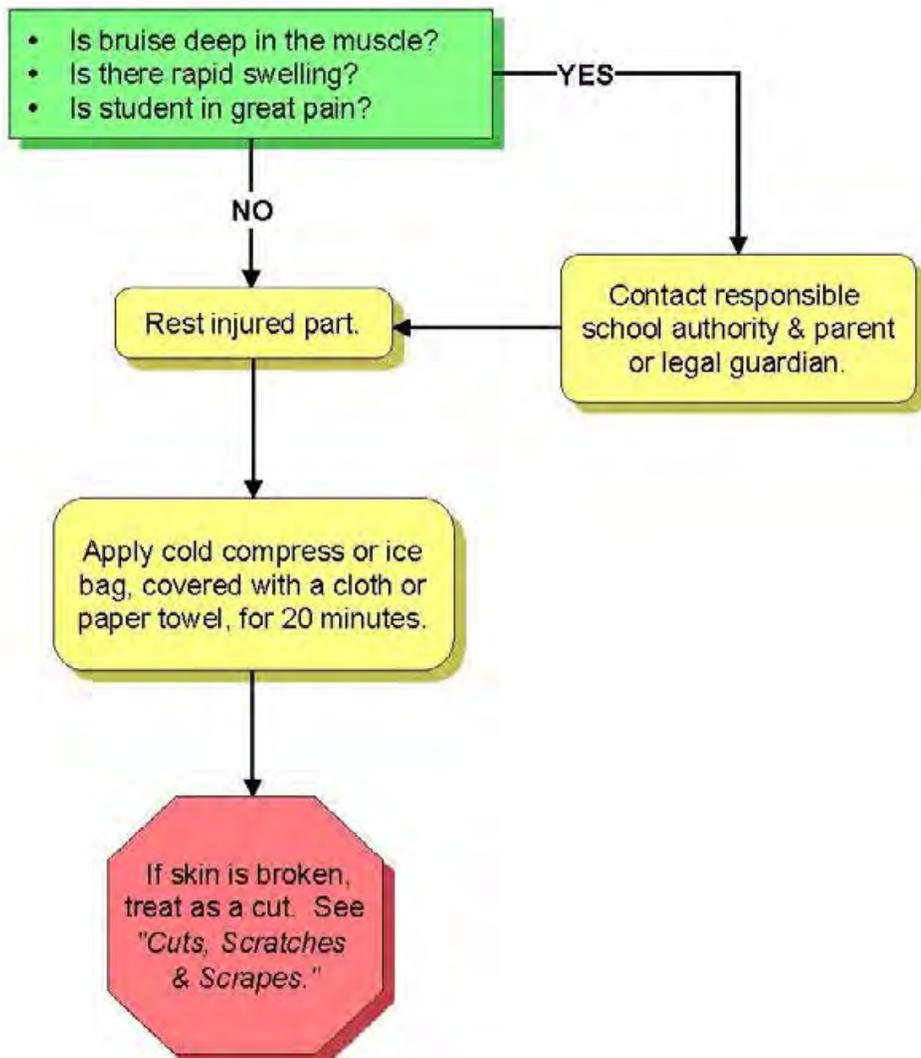


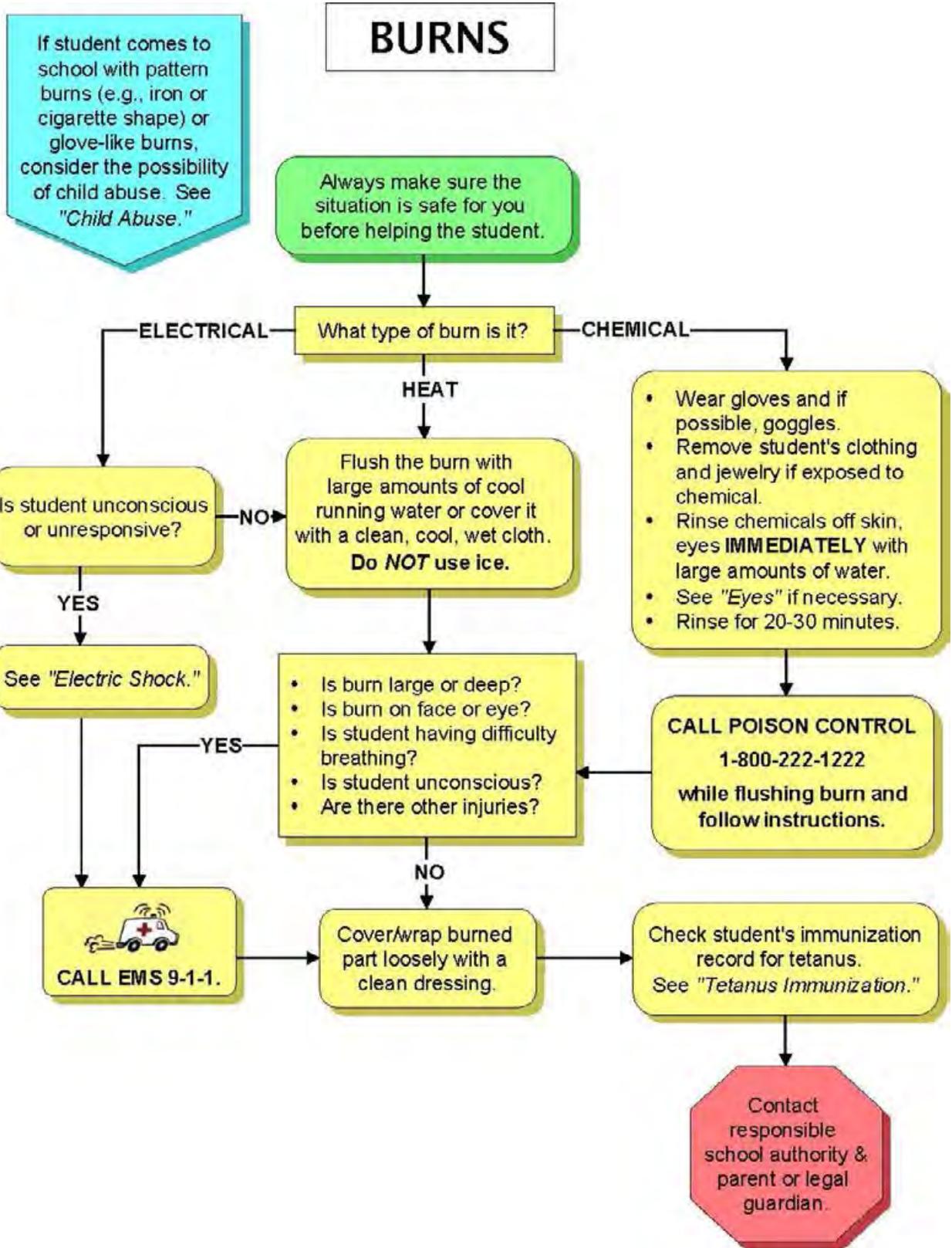
# BLISTERS (FROM FRICTION)



# BRUISES

If student comes to school with unexplained, unusual or frequent bruising, consider the possibility of child abuse. See "*Child Abuse.*"





# NOTES ON PERFORMING CPR

The American Heart Association (AHA) issued new CPR guidelines for laypersons in 2010.\* Other organizations such as the American Red Cross also offer CPR training classes. If the guidance in this book differs from the instructions you were taught, follow the methods you learned in your training class. In order to perform CPR safely and effectively, skills should be practiced in the presence of a trained instructor. It is a recommendation of these guidelines that anyone in a position to care for students should be properly trained in CPR.

Current first aid, choking and CPR manuals and wall chart(s) should also be available. The American Academy of Pediatrics offers the Pediatric First Aid for Caregivers and Teachers (PedFACTS) Resource Manual and 3-in-1 First Aid, Choking, CPR Chart for sale at <http://www.aap.org>.

## **CHEST COMPRESSIONS**

The AHA is placing more emphasis on the use of effective chest compressions in CPR. CPR chest compressions produce blood flow from the heart to the vital organs. To give effective compressions, rescuers should:

- Follow revised guidelines for hand use and placement based on age.
- Use a compression to breathing ratio of 30 compressions to 2 breaths.
- “Push hard and fast.” Compress chest at a rate of about 100 compressions per minute for all victims.
- Compress about 1/3 to ½ the depth of the chest for infants and children, and 1 ½ to 2 inches for adults.
- Allow the chest to return to its normal position between each compression.
- Use approximately equal compression and relaxation times.
- Try to limit interruptions in chest compressions.

## **BARRIER DEVICE**

Barrier devices, to prevent the spread of infections from one person to another, can be used when performing rescue breathing. Several different types (e.g., face shields, pocket masks) exist. It is important to learn and practice using these devices in the presence of a trained CPR instructor before attempting to use them in any emergency situation. Rescue breathing technique may be affected by these devices.



# CARDIOPULMONARY RESUSCITATION (CPR) FOR INFANTS UNDER 1 YEAR

CPR is to be used when an infant is unresponsive or when breathing or heart beat stops.

- 1 Gently shake infant. If no response, shout for help and send someone to call **EMS**.
- 2 Turn the infant onto his/her back as a unit by supporting the head and neck.
- 3 Lift chin up and out with one hand while pushing down on the forehead with the other to open the **AIRWAY**.
- 4 Check for **BREATHING**. With your ear close to infant's mouth, LOOK at the chest for movement, LISTEN for sounds of breathing and FEEL for breath on your cheek.
- 5 If infant is not breathing, take a normal breath. Seal your lips tightly around his/her mouth and nose. While keeping the airway open, give 1 normal breath over 1 second and watch for chest to rise.

## IF CHEST RISES WITH RESCUE BREATH (AIR GOES IN)

6. Find finger position near center of breastbone just below the nipple line. (Make sure fingers are **NOT** over the very bottom of the breastbone.)
7. Compress chest hard and fast 30 times with 2 fingers *about* 1/3 to 1/2 the depth of the infant's chest.  
  
Use equal compression and relaxation times. Limit interruptions in chest compressions.
8. Give 2 normal breaths, each lasting 1 second. Each breath should make chest rise.
9. REPEAT CYCLES OF 30 COMPRESSIONS TO 2 BREATHS AT A RATE OF 100 COMPRESSIONS PER MINUTE UNTIL INFANT STARTS BREATHING EFFECTIVELY ON OWN OR HELP ARRIVES.
10. Call EMS after 2 minutes (5 cycles of 30 compressions to 2 breaths) if not already called.

## IF CHEST DOES NOT RISE WITH RESCUE BREATH (AIR DOES NOT GO IN)

6. Re-Tilt head back. Try to give 2 breaths again.  
  
IF CHEST RISES WITH RESCUE BREATH,  
FOLLOW LEFT COLUMN.  
  
IF CHEST STILL DOES NOT RISE:
7. Find finger position near center of breastbone just below the nipple line. (Make sure fingers are not over the bottom of the breastbone.)
8. Using 2 or 3 fingers, give up to 5 chest thrusts near center of breastbone. (Make sure fingers are not over the bottom of the breastbone.)
9. Look in mouth. If foreign object is seen, remove it. Do not perform a blind finger sweep or lift the jaw or tongue.
10. REPEAT STEPS 6-9 UNTIL BREATHS GO IN, INFANT STARTS TO BREATHE ON OWN OR HELP ARRIVES.

# CARDIOPULMONARY RESUSCITATION (CPR) FOR CHILDREN 1 to 8 YEARS OF AGE

CPR is to be used when an infant is unresponsive or when breathing or heart beat stops.

1. Tap or gently shake the shoulder. Shout, "Are you okay?" If child is unresponsive, shout for help and send someone to call EMS and get your schools AED if available.
2. Turn the child onto his/her back as a unit by supporting the head and neck. If a head or neck injury is suspected, DO NOT BEND OR TURN NECK.
3. Lift chin up and out with one hand while pushing down on the forehead with the other to open the **AIRWAY**.
4. Check for normal BREATHING. With your ear close to child's mouth, take 5-10 seconds to LOOK at the chest for movement, LISTEN for sounds of breathing, and FEEL for breath on your cheek.
5. If you witnessed the child's collapse, first set up the AED and connect the pads according to the manufacturer's instructions. Incorporate use into CPR cycles according to instructions and training method. For an unwitnessed collapse, perform CPR for 2 minutes and then use AED.
6. If child is not breathing, take a normal breath. Seal your lips tightly around his/her mouth; pinch nose shut. While keeping airway open, give 1 breath over 1 second and watch for chest to rise.



## **IF CHEST RISES WITH RESCUE BREATH (AIR GOES IN)**

7. Find hand position near center of breastbone at the nipple line. (Do **NOT** place your hand over the very bottom of the breastbone.)
8. Compress chest hard and fast 30 times with the heel of **1 or 2 hands**.\* Compress about 1/3 to 1/2 depth of child's chest. Allow the chest to return to normal position between each compression.  
  
*Lift fingers to avoid pressure on ribs. Use equal compression and relaxation times. Limit interruptions in chest compressions.*
9. Give 2 normal breaths, each lasting 1 second. Each breath should make the chest rise.
10. REPEAT CYCLES OF 30 COMPRESSIONS TO 2 BREATHS AT A RATE OF 100 COMPRESSIONS PER MINUTE UNTIL CHILD STARTS BREATHING ON OWN OR HELP ARRIVES.
11. Call EMS after 2 minutes (5 cycles of 30 compressions to 2 rescue breaths) if not already called.

## **IF CHEST DOES NOT RISE WITH RESCUE BREATH (AIR DOES NOT GO IN):**

7. Re-tilt head back. Try to give two breaths again.

## **IF CHEST RISES WITH RESCUE BREATH, FOLLOW LEFT COLUMN.**

## **IF CHEST DOES NOT RISE:**

8. Find hand position near center of breast bone at the nipple line. (Do **NOT** place your hand over the very bottom of the breastbone.)
9. Compress chest fast and hard 5 times with the heel of **1-2 hands**.\* Compress about 1/3 to 1/2 depth of child's chest. Lift fingers to avoid pressure on the ribs.
10. Look in mouth. If foreign object is seen, remove it. Do **NOT** perform a blind finger sweep or lift the jaw or tongue.
11. REPEAT STEPS 6-9 UNTIL BREATHS GO IN, CHILD STARTS TO BREATHE EFFECTIVELY ON OWN, OR HELP ARRIVES.

### **\*Hand positions for child CPR:**

- 1 hand: Use heel of 1 hand only.
- 2 hands: Use heel of 1 hand with second on top of first.

# CARDIOPULMONARY RESUSCITATION (CPR) FOR CHILDREN OVER 8 YEARS OF AGE & ADULTS

**CPR is to be used when an infant is unresponsive or when breathing or heart beat stops.**

1. Tap or gently shake the shoulder. Shout, "Are you okay?" If child is unresponsive, shout for help and send someone to call EMS and get your schools AED if available.
2. Turn the child onto his/her back as a unit by supporting the head and neck. If a head or neck injury is suspected, **DO NOT BEND OR TURN NECK.**
3. Lift chin up and out with one hand while pushing down on the forehead with the other to open the **AIRWAY.**
4. Check for normal BREATHING. With your ear close to child's mouth, take 5-10 seconds to LOOK at the chest for movement, LISTEN for sounds of breathing, and FEEL for breath on your cheek.
5. If you witnessed the child's collapse, first set up the AED and connect the pads according to the manufacturer's instructions. Incorporate use into CPR cycles according to instructions and training method. For an unwitnessed collapse, perform CPR for 2 minutes and then use AED.
6. If child is not breathing, take a normal breath. Seal your lips tightly around his/her mouth; pinch nose shut. While keeping airway open, give 1 breath over 1 second and watch for chest to rise.



**IF CHEST RISES WITH RESCUE BREATH (AIR GOES IN)**

7. Give a second rescue breath lasting 1 second until chest rises.
8. Place heel of one hand on top of the center of the breastbone. Place heel of other hand on top of the first. Interlock fingers. (Do **NOT** place your hands over the very bottom of the breastbone.)
9. Position self vertically above victim's chest and with straight arms, **compress chest hard and fast about 1 ½ to 2 inches 30 times in a row with both hands.** Allow chest to return to normal between each compression. *Lift fingers when pressing to avoid pressure on ribs.* Limit interruptions to chest compressions.
10. Give 2 normal breaths, each lasting 1 second. Each breath should make the chest rise.
10. REPEAT CYCLES OF 30 COMPRESSIONS TO 2 BREATHS AT A RATE OF 100 COMPRESSIONS PER MINUTE UNTIL CHILD STARTS BREATHING ON OWN OR HELP ARRIVES.
11. Call EMS after 2 minutes (5 cycles of 30 compressions to 2 rescue breaths) if not already called.

**IF CHEST DOES NOT RISE WITH RESCUE BREATH (AIR DOES NOT GO IN):**

7. Re-tilt head back. Try to give two breaths again.

**IF CHEST RISES WITH RESCUE BREATH, FOLLOW LEFT COLUMN.**

**IF CHEST DOES NOT RISE:**

8. Place heel of one hand on top of the center of the breastbone. Place heel of other hand on top of the first. Interlock fingers. (Do **NOT** place your hands over the very bottom of the breastbone.)
9. Position self vertically above person's chest and with straight arms, compress chest 30 times with both hands *about 1 ½ to 2 inches.* Lift fingers to avoid pressure on ribs.
10. Look in mouth. If foreign object is seen, remove it. Do **NOT** perform a blind finger sweep or lift the jaw or tongue.
11. REPEAT STEPS 6-9 UNTIL BREATHS GO IN, PERSON STARTS TO BREATHE EFFECTIVELY ON OWN, OR HELP ARRIVES.

# CHOKING (Conscious Victims)

Call EMS 9-1-1 after starting rescue efforts.

## INFANTS UNDER 1 YEAR

Begin the following if the infant is choking and is unable to breathe. However, if the infant is coughing or crying, do **NOT** do any of the following, but call EMS, try to calm the child and watch for worsening of symptoms. If cough becomes ineffective (loss of sound), begin step 1 below.

1. Position the infant, with head slightly lower than chest, face down on your arm and support the head (support jaw; do **NOT** compress throat).
2. Give up to 5 back slaps with the heel of hand between infant's shoulder blades.
3. If object is not coughed up, position infant face up on your forearm with head slightly lower than rest of body.
4. With 2 or 3 fingers, give up to 5 chest thrusts near center of breastbone, just below the nipple line.
5. Open mouth and look. If foreign object is seen, sweep it out with finger.
6. Tilt head back and lift chin up and out to open the airway. Try to give 2 breaths.
7. REPEAT STEPS 1-6 UNTIL OBJECT IS COUGHED UP OR INFANT STARTS TO BREATHE OR BECOMES UNCONSCIOUS.
8. Call EMS after 2 minutes (5 cycles of 30 compressions to 2 rescue breaths) if not already called.

**IF INFANT BECOMES UNCONSCIOUS,  
GO TO STEP 6 OF INFANT CPR.**

## CHILDREN OVER 1 YEAR OF AGE & ADULTS

Begin the following if the victim is choking and unable to breathe. Ask the victim: "Are you choking?" If the victim nods yes or can't respond, help is needed. However, if the victim is coughing, crying or speaking, do **NOT** do any of the following, but call EMS, try to calm him/her and watch for worsening of symptoms. If cough becomes ineffective (loss of sound) and victim cannot speak, begin step 1 below.



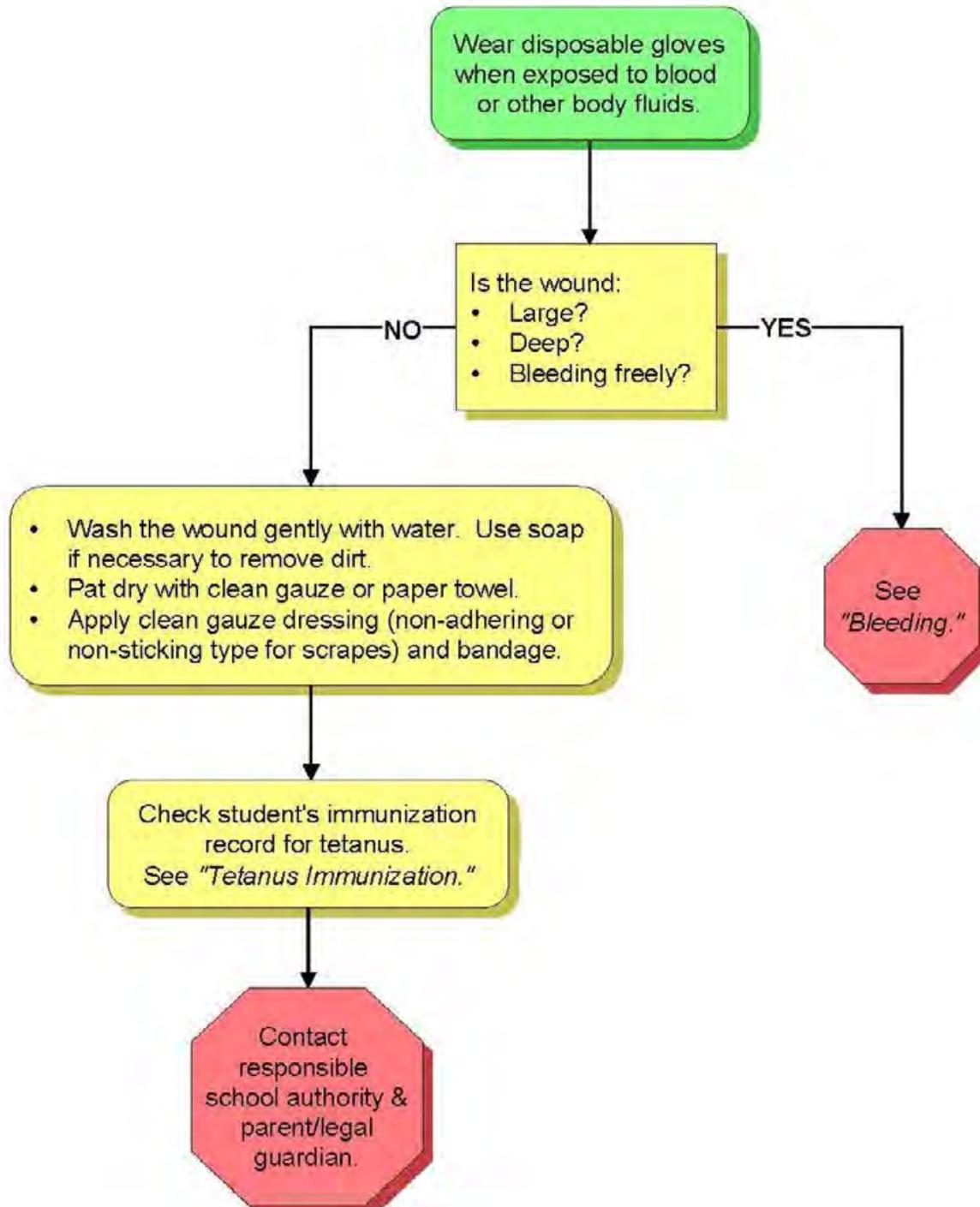
1. Stand or kneel behind child with arms encircling child.
2. Place thumbside of fist against middle of abdomen just above the navel. (Do **NOT** place your hand over the very bottom of the breastbone. Grasp fist with other hand.)
3. Give up to 5 quick inward and upward abdominal thrusts.
4. REPEAT STEPS 1-2 UNTIL OBJECT IS COUGHED UP, CHILD STARTS TO BREATHE OR CHILD BECOMES UNCONSCIOUS.

**IF CHILD BECOMES UNCONSCIOUS,  
PLACE ON BACK AND GO TO STEP 7 OF  
CHILD OR ADULT CPR.**

### FOR OBESE OR PREGNANT PERSONS:

Stand behind person and place your arms under the armpits to encircle the chest. Press with quick backward thrusts.

# CUTS (SMALL), SCRATCHES & SCRAPES (INCLUDING ROPE & FLOOR BURNS)



# EARS

## DRAINAGE FROM EAR

Do *NOT* try to clean out ear.

Contact responsible school authority & parent or legal guardian.  
**URGE MEDICAL CARE.**

## EARACHE

Contact responsible school authority & parent/legal guardian.  
**URGE MEDICAL CARE.**

## OBJECT IN EAR CANAL

Ask student if he/she knows what is in the ear.

Do you suspect a live insect is in the ear?

NO

Gently tilt head toward the affected side.

Did object come out on its own?

YES

If there is no pain, the student may return to class. Notify the parent or legal guardian.

YES OR NOT SURE

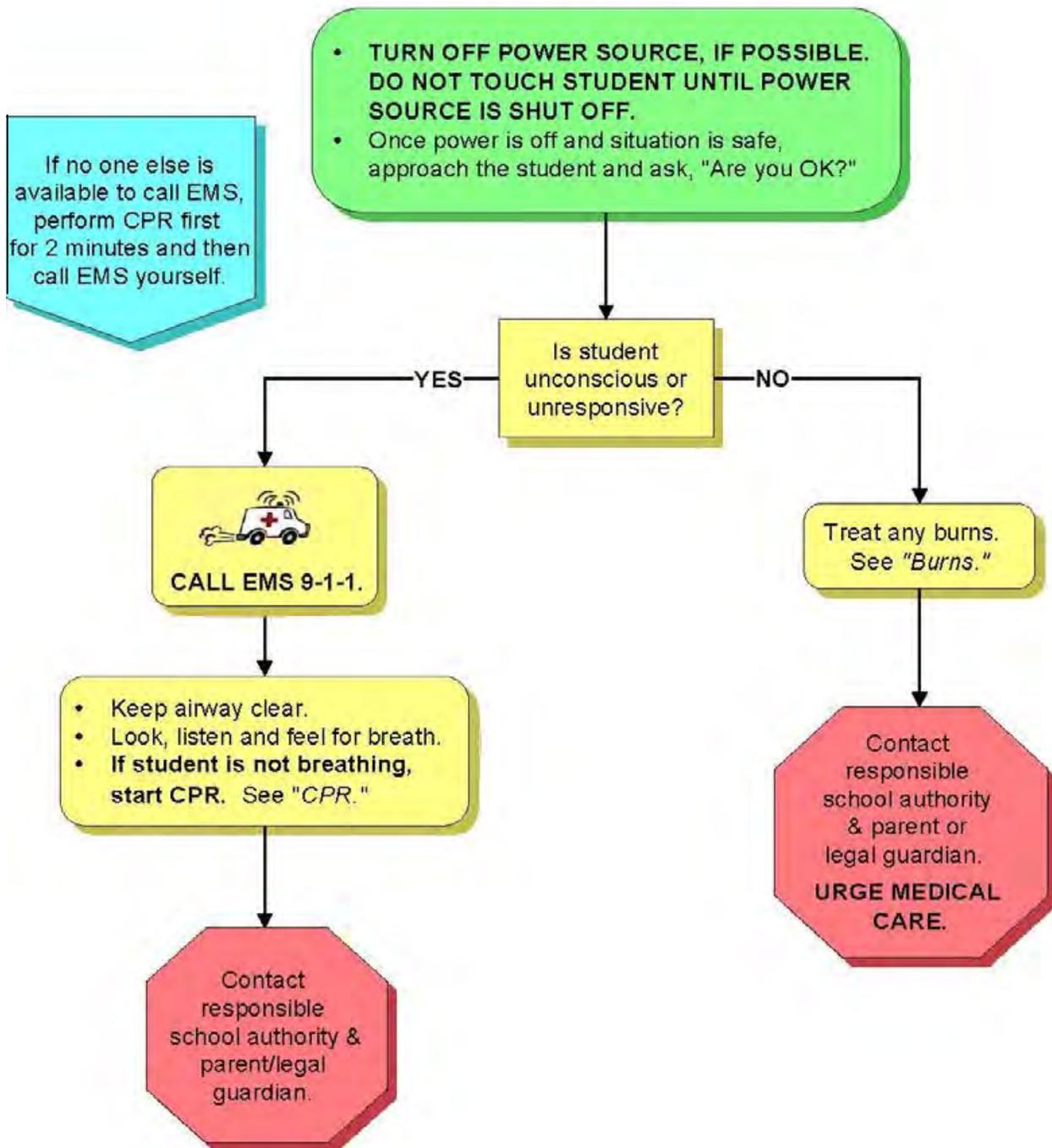
Do *NOT* attempt to remove.

Contact responsible school authority & parent or legal guardian.  
**URGE MEDICAL CARE.**

Do *NOT* attempt to remove.

NO

# ELECTRIC SHOCK



# EYES

## EYE INJURY:

With any eye problem, ask the student if he/she wears contact lenses. Have student remove contacts before giving any first aid to eye.

Keep student lying flat and quiet.

- Is injury severe?
- Is there a change in vision?
- Has object penetrated eye?

YES

NO

If an object has penetrated the eye, do **NOT** remove object.

Cover eye with a paper cup or similar object to keep student from rubbing, but do **NOT** touch eye or put any pressure on eye.

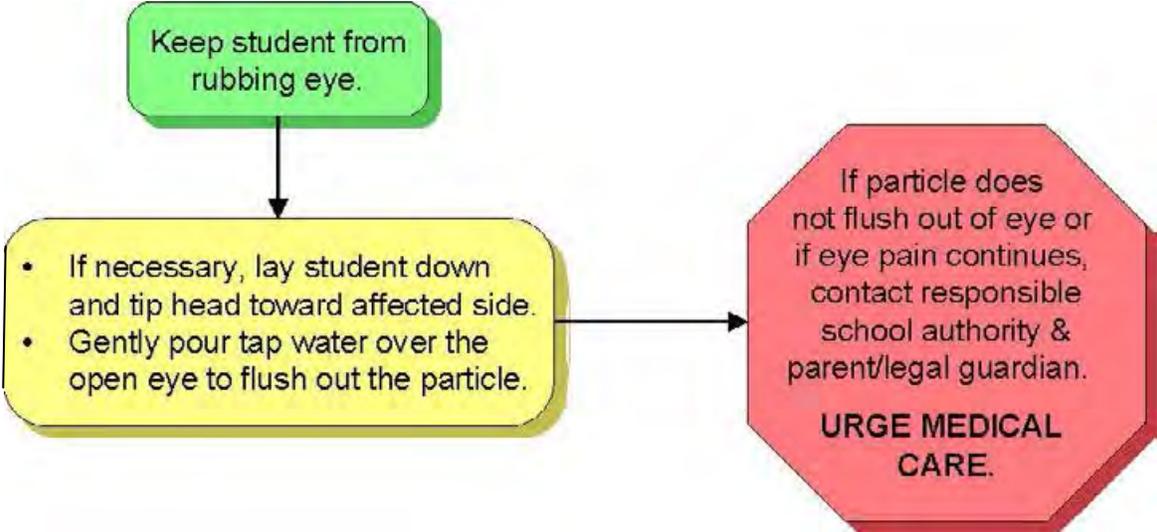


**CALL EMS 9-1-1.**  
Contact responsible school authority & parent or legal guardian.

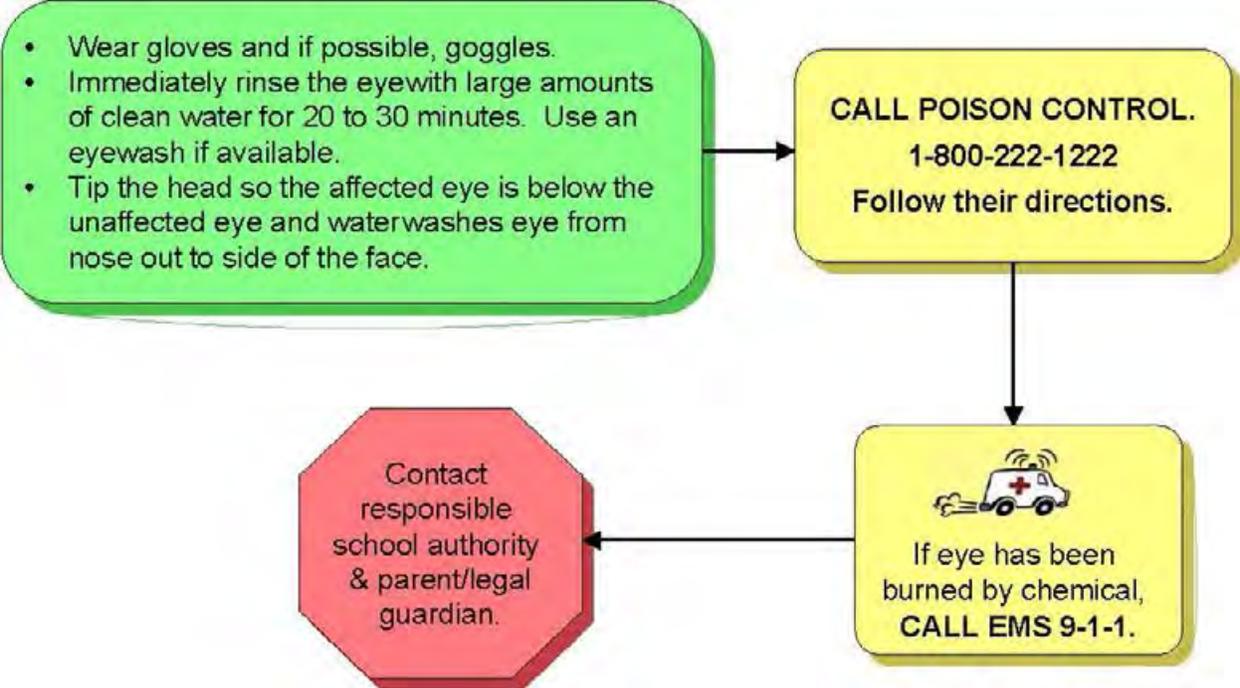
Contact responsible school authority & parent or legal guardian.  
**URGE IMMEDIATE MEDICAL CARE.**

# EYES

## PARTICLE IN EYE



## CHEMICALS IN EYE



# FAINTING

Fainting may have many causes including:

- Injuries.
- Illness.
- Blood loss/shock.
- Heat exhaustion.
- Diabetic reaction.
- Severe allergic reaction.
- Standing still for too long.

If you know the cause of the fainting, see the appropriate guideline.

If you observe any of the following signs of fainting, have the student lie down to prevent injury from falling:

- Extreme weakness or fatigue.
- Dizziness or light-headedness.
- Extreme sleepiness.
- Pale, sweaty skin.
- Nausea.

Most students who faint will recover quickly when lying down. If student does not regain consciousness immediately, see "Unconsciousness."

YES OR NOT SURE

- Is fainting due to injury?
- Was student injured when he/she fainted?

NO

Treat as possible neck injury. See "Neck & Back Pain." Do **NOT** move student.

- Keep student in flat position.
- Elevate feet.
- Loosen clothing around neck and waist.

- Keep airway clear and monitor breathing.
- Keep student warm, but not hot.
- Control bleeding if needed (wear disposable gloves).
- Give nothing by mouth.

Are symptoms (*dizziness, light-headedness, weakness, fatigue, etc*) still present?

YES

Keep student lying down. Contact responsible school authority & parent or legal guardian.

**URGE MEDICAL CARE.**

NO

Contact responsible school authority & parent/legal guardian.

If student feels better, and there is no danger of neck injury, he/she may be moved to a quiet, private area.

# FINGER/TOENAIL INJURY

Assess history of injury and examine injury. A crush injury to fingertip may result in fracture or bleeding under intact fingernail, creating pressure that may be very painful.

- Wear gloves if bleeding.
- Use gentle direct pressure until bleeding stops.
- Wash with soap and water, apply band-aid, or tape overlay to protect nail bed.
- Apply ICE PACK for 10-20 minutes for pain and prevention of swelling.

NO

After 20 minutes of ICE, has pain subsided?

YES

If you suspect a fracture,  
see "Fractures..."

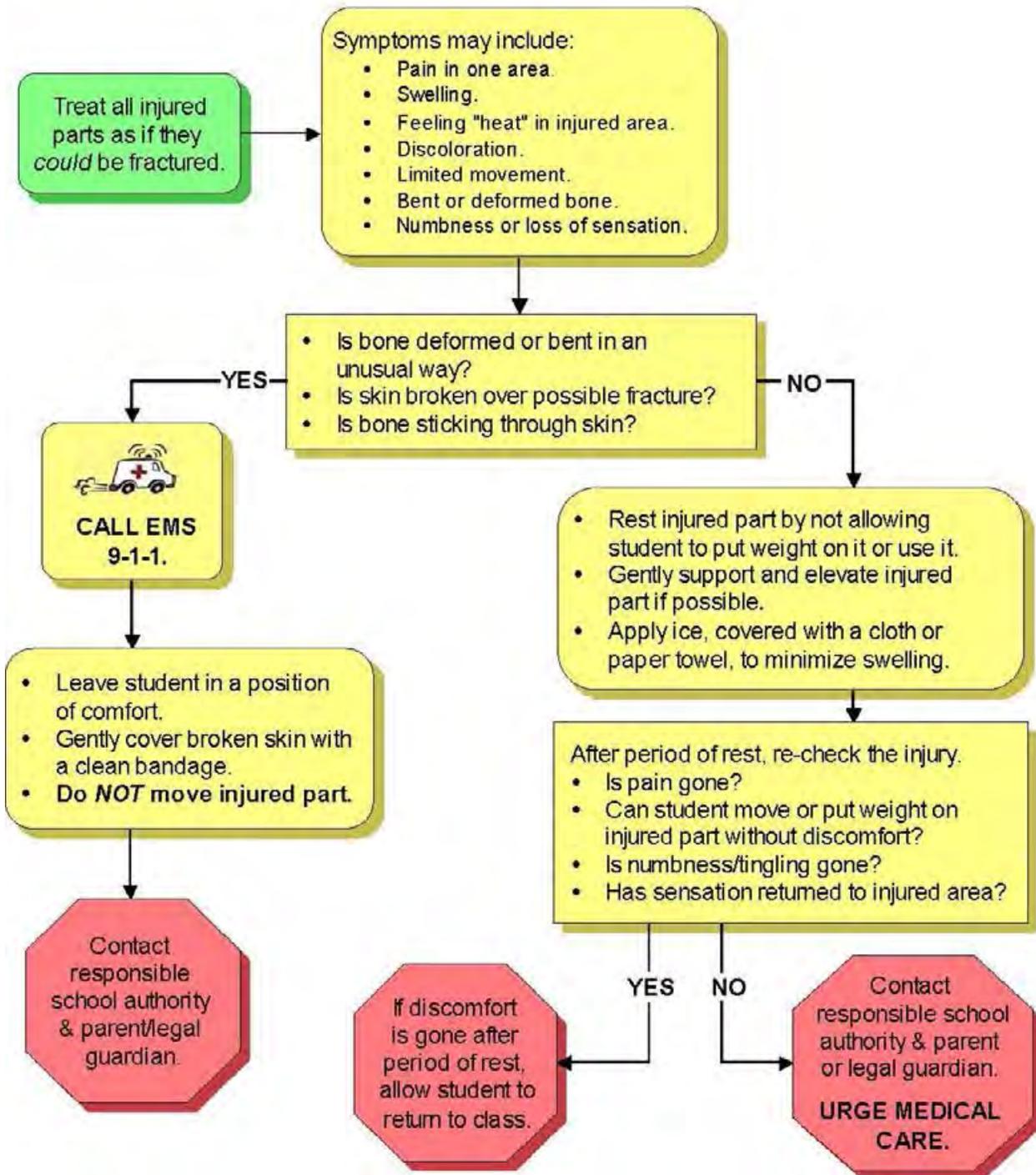
Return to class.

Contact responsible school  
nurse or administrator &  
parent/legal guardian.

**ENCOURAGE MEDICAL CARE**

Contact responsible  
school nurse  
or  
administrator &  
parent/legal guardian.

# FRACTURES, DISLOCATIONS, SPRAINS OR STRAINS



# FROSTBITE

Frostbite can result in the same type of tissue damage as a burn. It is a serious condition and requires medical attention.

Exposure to cold even for short periods of time may cause "HYPOTHERMIA" in children (see "*Hypothermia*"). The nose, ears, chin, cheeks, fingers and toes are the parts most often affected by frostbite.

Frostbitten skin may:

- Look discolored (flushed, grayish-yellow, pale).
- Feel cold to the touch.
- Feel numb to the student.

Deeply frostbitten skin may:

- Look white or waxy.
- Feel firm or hard (frozen).

- Take the student to a warm place.
- Remove cold or wet clothing and give student warm, dry clothes.
- Protect cold part from further injury.
- **Do NOT rub or massage the cold part or apply heat such as a water bottle or hot running water.**
- Cover part loosely with nonstick, sterile dressings or dry blanket.

Does extremity/part:

- Look discolored - grayish, white or waxy?
- Feel firm/hard (frozen)?
- Have a loss of sensation?

YES

NO

  
**CALL EMS 9-1-1.**  
Keep student warm and part covered.

Keep student and part warm.

Contact responsible authority & parent or legal guardian.

Contact responsible authority & parent or legal guardian.  
**Encourage medical care.**

# HEAD INJURIES

Many head injuries that happen at school are minor. Head wounds may bleed easily and form large bumps. Bumps to the head may not be serious. Head injuries from falls, sports and violence may be serious. If head is bleeding, see "Bleeding."

If student *only* bumped head and does not have any other complaints or symptoms, see "Bruises."

- With a head injury (*other than head bump*), always suspect neck injury as well.
- **Do NOT move or twist the back or neck.**
- See "Neck & Back Pain" for more information.

- Have student rest, lying flat.
- Keep student quiet and warm.

Is student vomiting?

Turn the head and body together to the side, keeping the head and neck in a straight line with the trunk.

Watch student closely. Do NOT leave student alone.

- Are any of the following symptoms present:
- Unconsciousness?
  - Seizure?
  - Neck pain?
  - Student is unable to respond to simple commands?
  - Blood or watery fluid in the ears?
  - Student is unable to move or feel arms or legs?
  - Blood is flowing freely from the head?
  - Student is sleepy or confused?

 CALL EMS 9-1-1.

- Check student's airway.
- Look, listen and feel for breathing.
- If student stops breathing, start CPR. See "CPR."

Give nothing by mouth. Contact responsible school authority & parent or legal guardian.

Even if student was only briefly confused and seems fully recovered, contact responsible school authority & parent or legal guardian. **URGE MEDICAL CARE.** Watch for delayed symptoms.

# HEAT STROKE - HEAT EXHAUSTION

Heat emergencies are caused by spending too much time in the heat. Heat emergencies can be life-threatening situations.

Strenuous activity in the heat may cause heat-related illness. Symptoms may include:

- Red, hot, dry skin.
- Weakness and fatigue.
- Cool, clammy hands.
- Vomiting.
- Loss of consciousness.

• Remove student from the heat to a cooler place.  
• Have student lie down.

Is student unconscious or losing consciousness?

• Quickly remove student from heat to a cooler place.  
• Put student on his/her side to protect the airway.  
• Look, listen and feel for breath.  
• **If student stops breathing, start CPR. See "CPR."**

• Does student have hot, dry, red skin?  
• Is student vomiting?  
• Is student confused?

Cool rapidly by completely wetting clothing with room temperature water.  
**Do NOT use ice water.**

Give clear fluids such as water, 7Up or Gatorade frequently in small amounts if student is fully awake and alert.

Contact responsible authority & parent/legal guardian.

  
**CALL EMS 9-1-1.**  
Contact responsible authority & parent or legal guardian.

# HYPOTHERMIA (EXPOSURE TO COLD)

Hypothermia happens after exposure to cold when the body is no longer capable of warming itself. Young children are particularly susceptible to hypothermia. It can be a life-threatening condition if left untreated for too long.

Hypothermia can occur after a student has been outside in the cold or in cold water. Symptoms may include:

- Confusion.
- Weakness.
- Blurry vision.
- Slurred speech.
- Shivering.
- Sleepiness.
- White or grayish skin color.
- Impaired judgment.

- Take the student to a warm place.
- Remove cold or wet clothing and wrap student in a warm, dry blanket.

Does student have:

- Loss of consciousness?
- Slowed breathing?
- Confused or slurred speech?
- White, grayish or blue skin?

Continue to warm student with blankets. If student is fully awake and alert, offer warm (**NOT hot**) fluids, but no food.

**CALL EMS 9-1-1.**

- Give nothing by mouth.
- Continue to warm student with blankets.
- If student is sleepy or losing consciousness, place student on his/her side to protect airway.
- Look, listen and feel for breathing.
- **If student stops breathing, start CPR.** See "CPR".



Contact responsible authority & parent or legal guardian.  
**Encourage medical care.**

# MOUTH & JAW INJURIES

Check student's immunization record for tetanus. See "Tetanus Immunization."

Wear disposable gloves when exposed to blood or other body fluids.

Do you suspect a head injury other than mouth or jaw?

See "Head Injuries."

See "Teeth."

Have teeth been injured?

Has jaw been injured?

- Do **NOT** try to move jaw.
- Gently support jaw with hand.

If tongue, lips or cheeks are bleeding, apply direct pressure with sterile gauze or clean cloth.

Contact responsible school authority & parent/legal guardian.  
**URGE IMMEDIATE MEDICAL CARE.**

- Is cut large or deep?
- Is there bleeding that cannot be stopped?

See "Bleeding."

Contact responsible school authority & parent/legal guardian.  
**Encourage medical care.**

Place a cold compress over the area to minimize swelling.

# NECK & BACK PAIN

Suspect a neck/back injury if pain results from:

- Falls over 10 feet or falling on head.
- Being thrown from a moving object.
- Sports.
- Violence.
- Being struck by a car or fast moving object.

Has an injury occurred?

NO →

A stiff or sore neck from sleeping in a "funny" position is different than neck pain from a sudden injury. Non-injured stiff necks may be uncomfortable but they are not emergencies.

YES ↓

Did student walk in or was student found lying down?

WALK IN →

If student is so uncomfortable that he or she is unable to participate in normal activities, contact responsible school authority & parent/legal guardian.

LYING DOWN ↓

- Do **NOT** move student unless there is **IMMEDIATE** danger of further physical harm.
- If student must be moved, support head and neck and move student in the direction of the head without bending the spine forward.
- Do **NOT** drag the student sideways.

Have student lie down on his/her back. Support head by holding it in a "face forward" position.  
Try **NOT** to move neck or head.

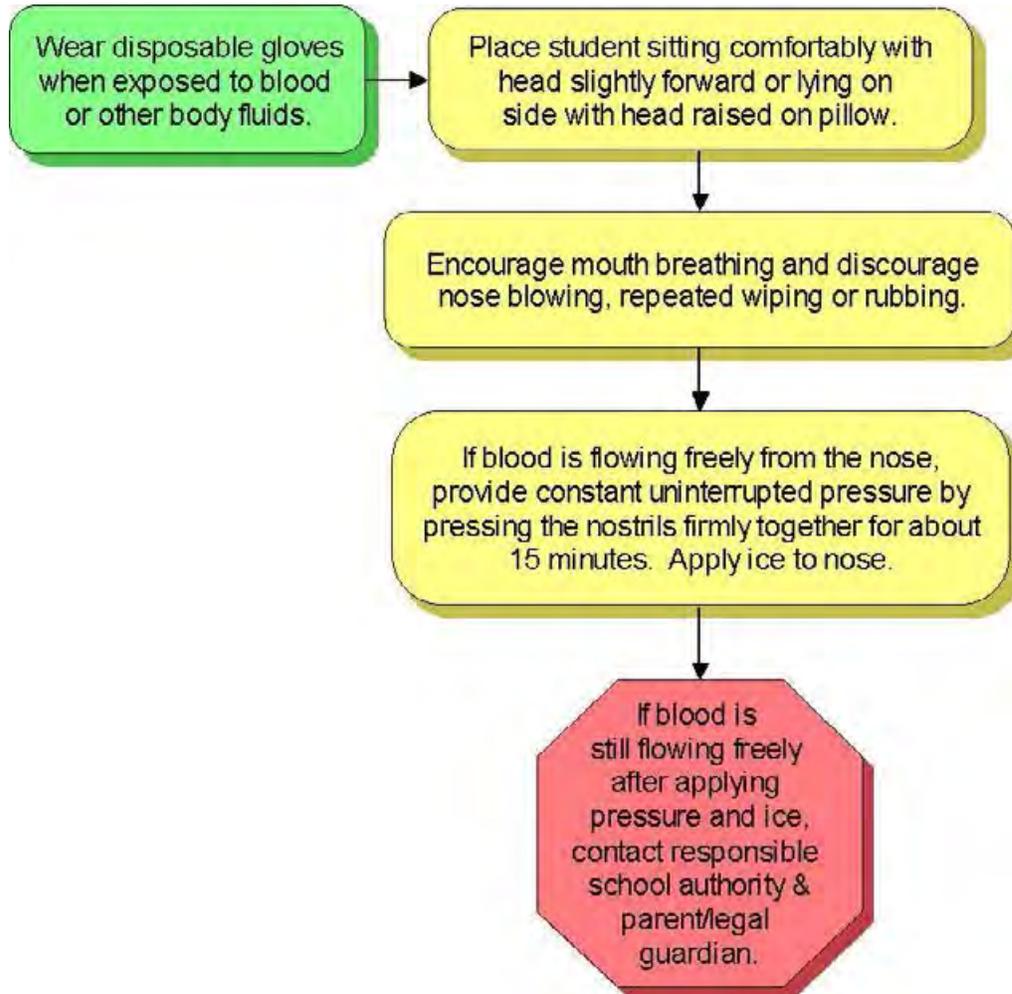
- Keep student quiet and warm.
- Hold the head still by gently placing one of your hands on each side of the head.

  
**CALL EMS 9-1-1.**  
 Contact responsible school authority & parent or legal guardian.

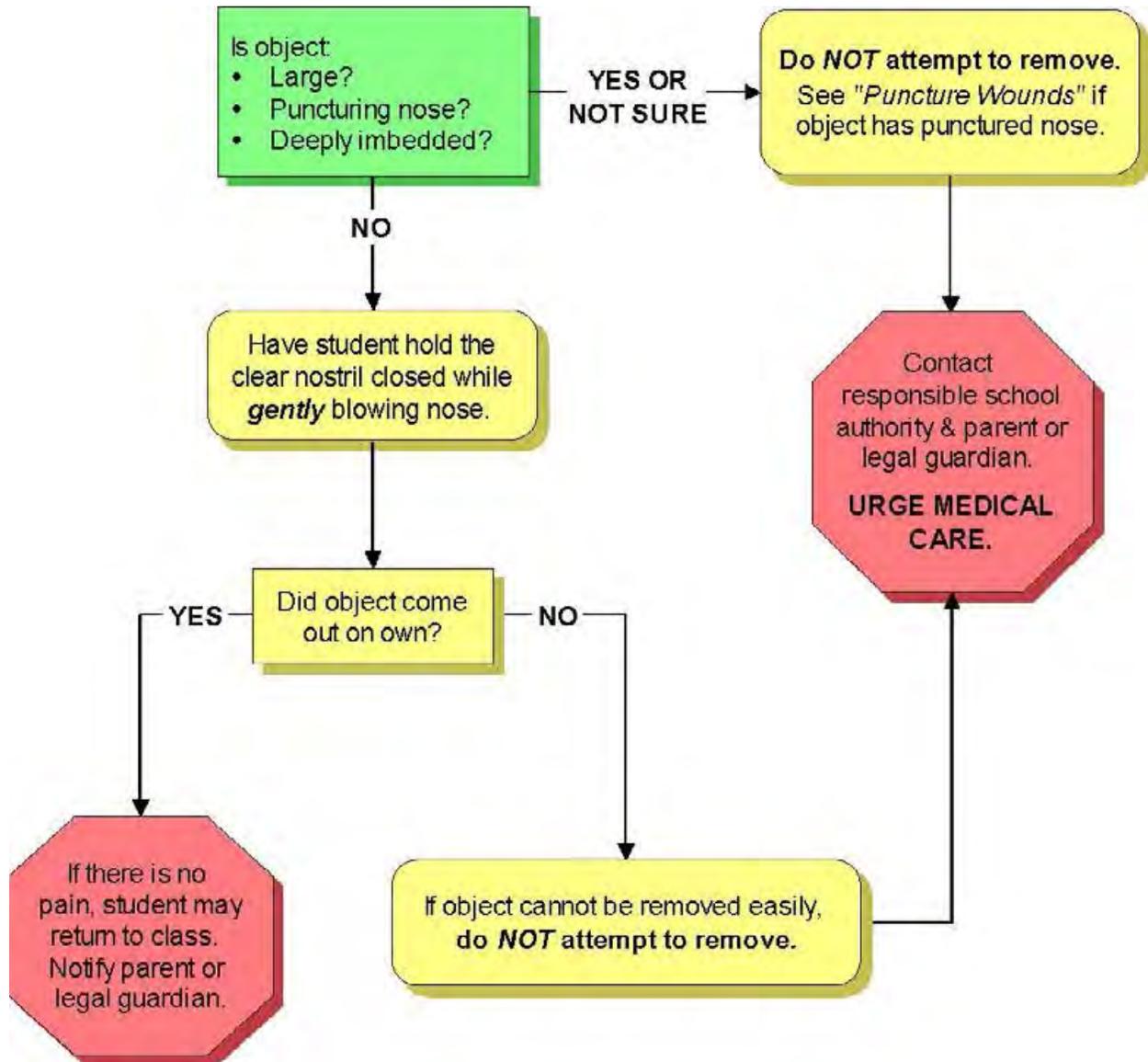
# NOSE

See "Head Injuries" if you suspect a head injury other than a nose-bleed or broken nose.

## NOSEBLEED



## OBJECT IN NOSE



# POISONING & OVERDOSE

Poisons can be swallowed, inhaled, absorbed through the skin or eyes, or injected. Call Poison Control when you suspect poisoning from:

- Medicines.
  - Insect bites and stings.
  - Snake bites.
  - Plants.
  - Chemicals/cleaners.
  - Drugs/alcohol.
  - Food poisoning.
  - Inhalants.
- Or if you are not sure.

Possible warning signs of poisoning include:

- Pills, berries or unknown substance in student's mouth.
- Bumps around mouth or on skin.
- Strange odor on breath.
- Sweating.
- Upset stomach or vomiting.
- Dizziness or fainting.
- Seizures or convulsions.

- Wear disposable gloves.
- Check student's mouth.
- Remove any remaining substance(s) from mouth.

- Do **NOT** induce vomiting or give anything **UNLESS** instructed to by Poison Control. With some poisons, vomiting can cause greater damage.
- Do **NOT** follow the antidote label on the container; it may be incorrect.

If possible, find out:

- Age and weight of student.
- What the student swallowed.
- What type of "poison" it was.
- How much and when it was taken.

**CALL POISON CONTROL.**  
**1-800-222-1222**  
**Follow their directions.**

- If student becomes unconscious, place on his/her side. Check airway.
- Look, listen and feel for breathing.
- If student stops breathing, start CPR. See "CPR."

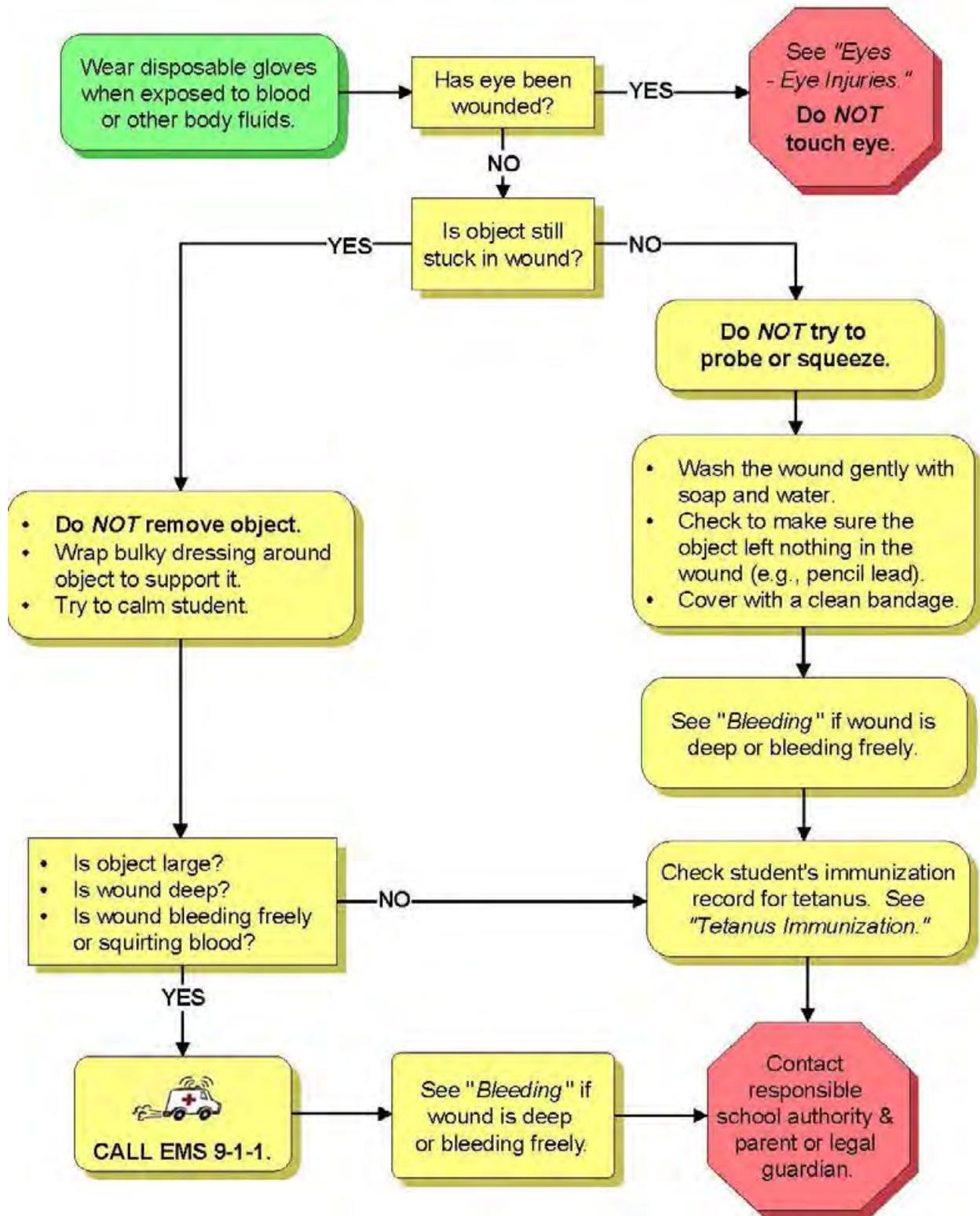
**CALL EMS 9-1-1.**

Contact responsible school authority & parent or legal guardian.



Send sample of the vomited material and ingested material with its container (if available) to the hospital with the student.

# PUNCTURE WOUNDS



# SHOCK

If injury is suspected, see *"Neck & Back Pain"* and treat as a possible neck injury.  
**Do NOT move student unless he/she is endangered.**

- Any serious injury or illness may lead to shock, which is a lack of blood and oxygen getting to the body tissues.
- Shock is a life-threatening condition.
- Stay calm and get immediate assistance.
- Check for medical bracelet or student's emergency care plan if available.

**See the appropriate guideline to treat the most severe (life or limb threatening) symptoms first.**  
Is student:

- Not breathing? See *"CPR"* and/or *"Choking."*
- Unconscious? See *"Unconsciousness."*
- Bleeding profusely? See *"Bleeding."*

NO

- Keep student in flat position of comfort.
- Elevate feet 8-10 inches, unless this causes pain or a neck/back or hip injury is suspected.
- Loosen clothing around neck and waist.
- Keep body normal temperature. Cover student with a blanket or sheet.
- Give nothing to eat or drink.
- If student vomits, roll onto left side keeping back and neck in straight alignment if injury is suspected.

## Signs of Shock:

- Pale, cool, moist, skin.
- Mottled, ashen, blue skin.
- Altered consciousness or confused.
- Nausea, dizziness or thirst.
- Severe coughing, high pitched whistling sound.
- Blueness in the face.
- Fever greater than 100.0 F in combination with lethargy, loss of consciousness, extreme sleepiness, abnormal activity.
- Unresponsive.
- Difficulty breathing or swallowing.
- Rapid breathing.
- Rapid, weak pulse.
- Restlessness/irritability.

YES



**CALL EMS  
9-1-1.**

Contact responsible school authority & parent or legal guardian.  
**URGE MEDICAL CARE if EMS not called.**

# SNAKE BITE

**Treat all snake bites as poisonous until snake is positively identified.**

- **DO NOT** cut wound.
- **DO NOT** apply tourniquet.
- **DO NOT** apply ice.

**ALL SNAKE BITES**  
 Need medical evaluation. If you are going to be greater than 30 minutes from an emergency room, take a **SNAKE BITE KIT** for outdoor trips.

- Immobilize the bitten extremity at or below the level of the heart.
- Make person lie down, keep at complete rest, and avoid activity (walking).
- Keep victim warm and calm.
- Remove any restrictive clothing, rings, and watches.

- Is snake poisonous or unknown?
- Is person not breathing (See "CPR")?

YES →

**CALL EMS 9-1-1**

NO ↓

- Flush bite with large amount of water.
- Wash with soap and water.
- Cover with clean, cool compress, or moist dressing.
- Monitor pulse, color, and respirations; prepare to perform CPR if needed.
- Identify snake- if dead, send with victim to hospital.
- Parents pay transport for medical evaluation if condition is not life threatening.

**If greater than 30 minutes from emergency department:**

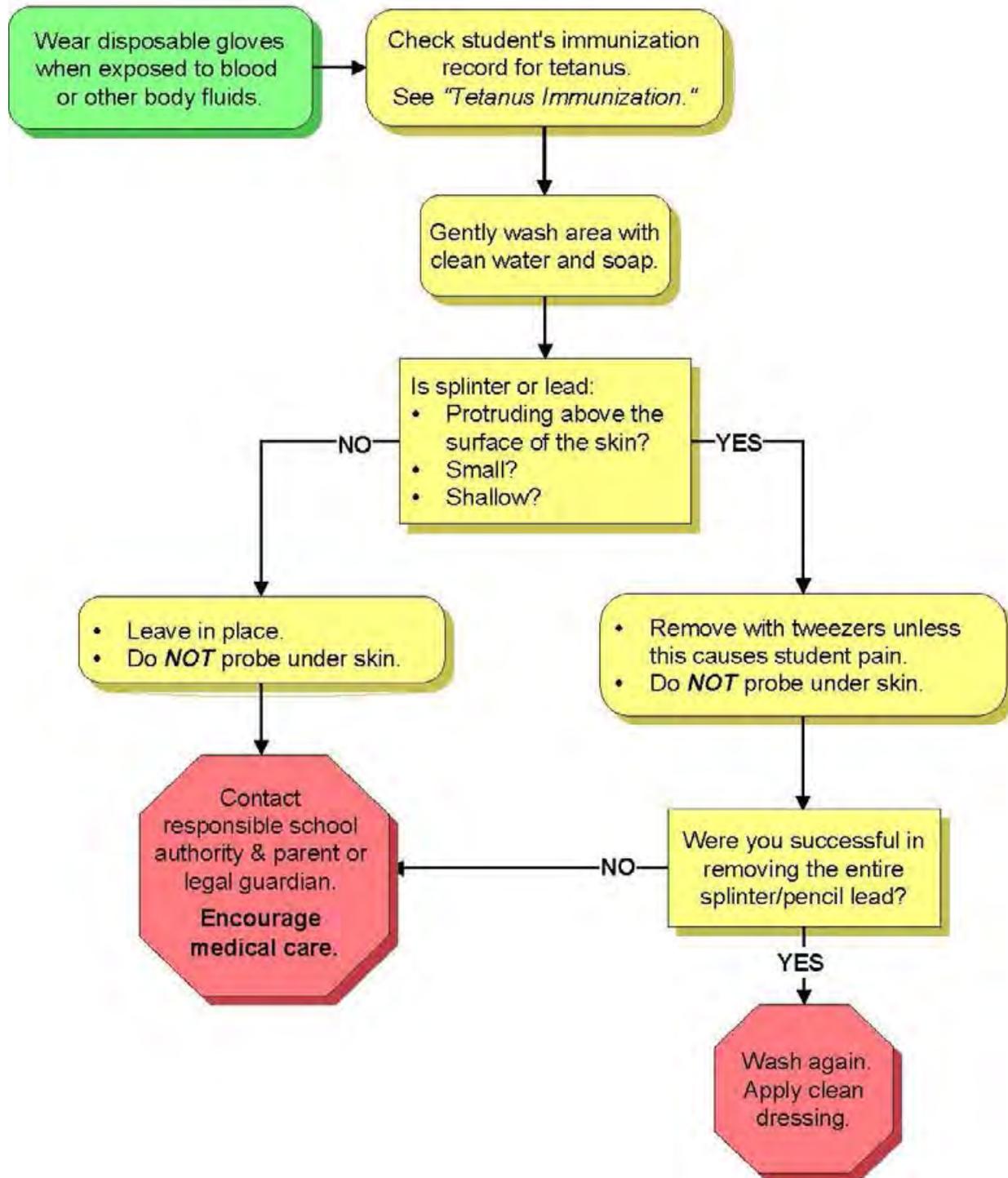
- Apply a tight bandage, to an extremity bite, between the bite and the heart; do not cut off blood flow.
- Use Snake Bite Kit suction device repeatedly.

Contact responsible school nurse or administrator & parent/legal guardian.  
**ENCOURAGE MEDICAL CARE**

**Signs & Symptoms of Poisonous Bite**

<p><b>Mild to Moderate:</b></p> <ul style="list-style-type: none"> <li>• Swelling, discoloration or pain at site.</li> <li>• Rapid pulse, weakness, sweating, or fever.</li> <li>• Shortness of breath.</li> <li>• Burning, numbness, or tingling sensation.</li> <li>• Blurred vision, dizziness, or fainting.</li> <li>• Fang marks, nausea, vomiting, and diarrhea.</li> </ul>	<p><b>Severe:</b></p> <ul style="list-style-type: none"> <li>• Swelling of tongue or throat.</li> <li>• Rapid swelling and numbness, severe pain, shock, pinpoint pupils, twitching, seizures, paralysis, and unconsciousness.</li> <li>• Loss of muscle coordination.</li> </ul>
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# SPLINTERS OR IMBEDDED PENCIL LEAD



# STINGS

Students with a history of allergy to stings should be known to all school staff. An emergency care plan should be developed.

Does student have:

- Difficulty breathing?
- A rapidly expanding area of swelling, especially of the lips, mouth or tongue?
- A history of allergy to stings?

NO

YES

A student may have a delayed allergic reaction up to **2 hours** after the sting. Adult(s) supervising student during normal activities should be aware of the sting and should watch for any delayed reaction.

Refer to student's emergency care plan.

If available, administer doctor- and parent- or guardian-approved medications.



CALL EMS 9-1-1.

- Remove stinger if present.
- Wash area with soap and water.
- Apply cold compress.

- Check student's airway.
- Look, listen and feel for breathing.
- **If student stops breathing, start CPR. See "CPR."**

Contact responsible school authority & parent or legal guardian.

See "Allergic Reaction."

# TEETH

## BLEEDING GUMS

Bleeding gums:

- Are generally related to chronic infection.
- Present some threat to student's general health.

No first aid measure in the school will be of any significant value.

Contact responsible school authority & parent/legal guardian.  
**URGE DENTAL CARE.**

## TOOTHACHE OR GUM INFECTION

See "Mouth & Jaw" for tongue, cheek, lip, jaw or other mouth injury not involving the teeth.

These conditions can be direct threats to student's general health, not just local tooth problems.

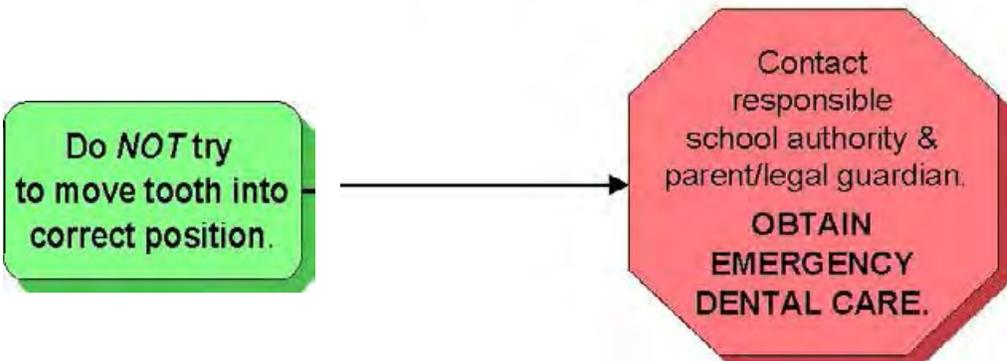
No first aid measure in the school will be of any significant value.

Relief of pain in the school often postpones dental care. **Do NOT** place pain relievers (e.g., aspirin, Tylenol) on the gum tissue of the aching tooth. They can burn tissue.

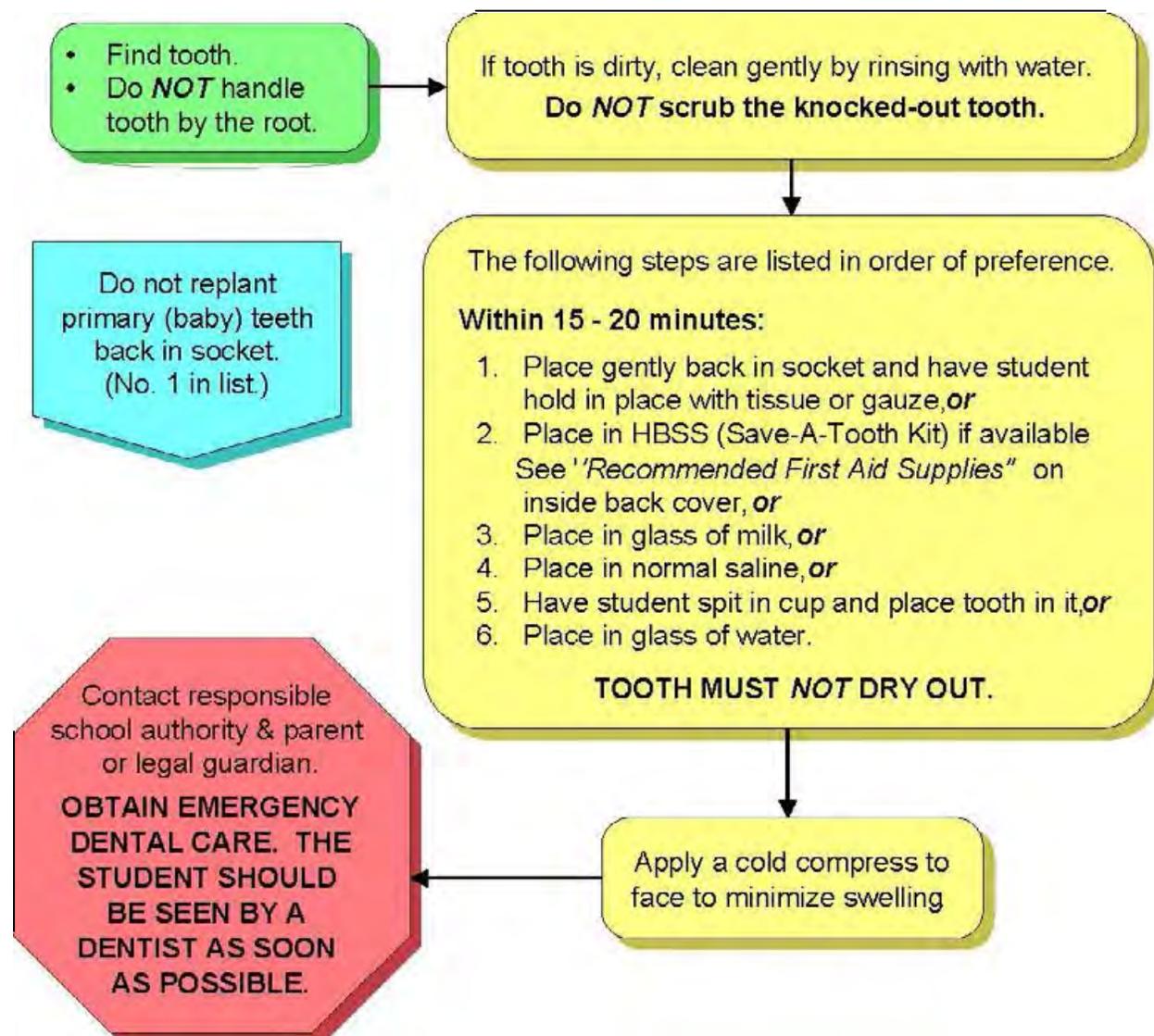
Contact responsible school authority & parent/legal guardian.  
**URGE DENTAL CARE.**

## DISPLACED TOOTH

# TEETH



## KNOCKED-OUT OR BROKEN PERMANENT TOOTH



# TICKS

Students should be inspected for ticks after time in woods or brush. Ticks may carry serious infections and must be completely removed. Do **NOT** handle ticks with bare hands.

Refer to your school's policy regarding the removal of ticks.

Wear disposable gloves when exposed to blood and other body fluids.

Wash the tick area gently with soap and water before attempting removal.

- Using tweezers, grasp the tick as close to the skin surface as possible and pull upward with steady, even pressure.
- Do **NOT** twist or jerk the tick as the mouth parts may break off. It is important to remove the **ENTIRE** tick.
- Take care not to squeeze, crush or puncture the body of the tick as its fluids may carry infection.

- After removal, wash the tick area thoroughly with soap and water.
- Wash your hands.
- Apply a bandage.

Ticks can be safely thrown away by placing them in container of alcohol or flushing them down the toilet.

Contact responsible school authority & parent/legal guardian.

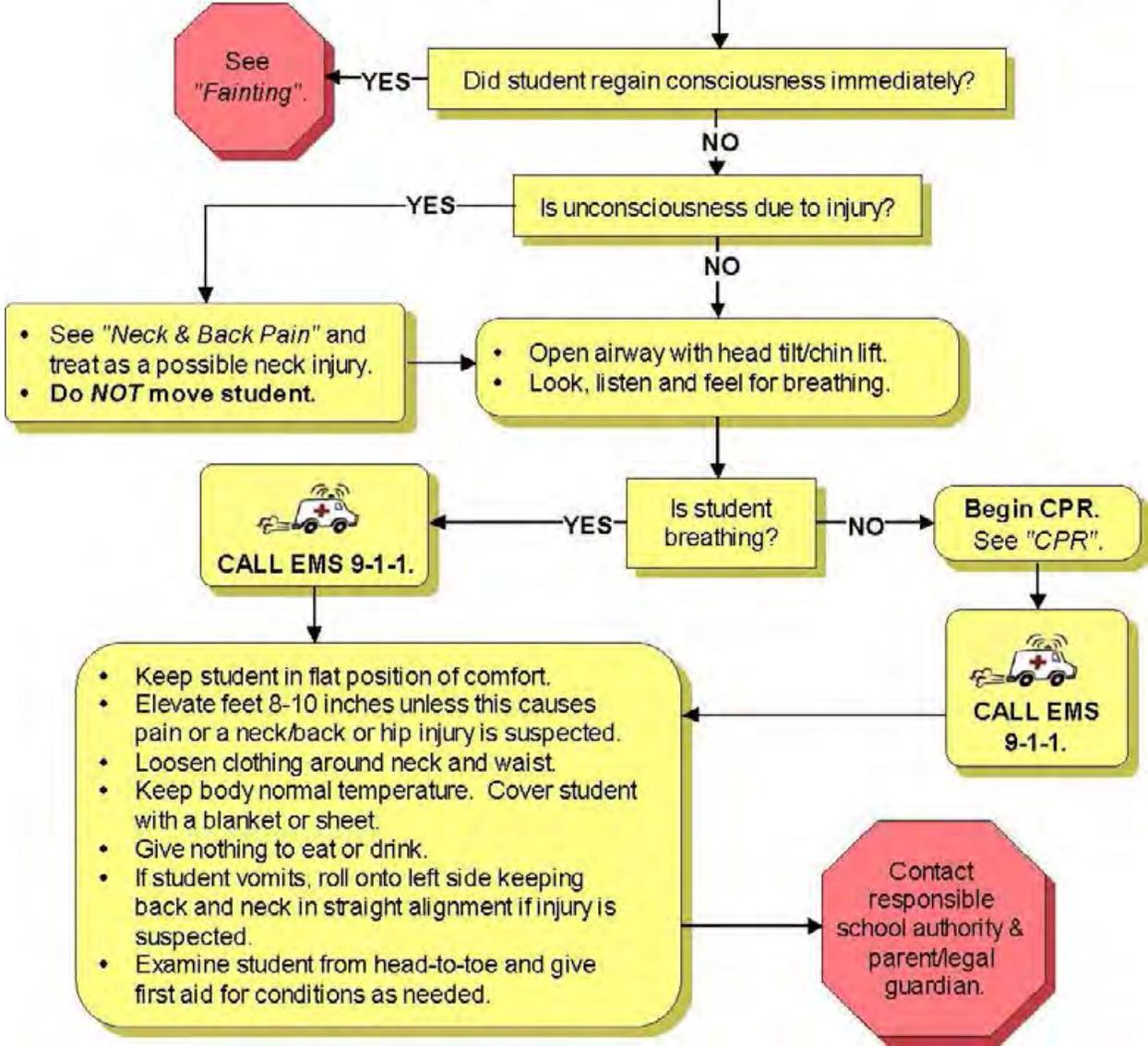
# UNCONSCIOUSNESS

If student stops breathing, and no one else is available to call EMS, administer CPR for 2 minutes and then call EMS yourself.

Unconsciousness may have many causes including:

- Injuries.
- Blood loss/shock.
- Poisoning.
- Severe allergic reaction.
- Diabetic reaction.
- Heat exhaustion.
- Illness.
- Fatigue.
- Stress.
- Not eating.

If you know the cause of the unconsciousness, see the appropriate guideline.



# EMERGENCY PHONE NUMBERS

Complete this page, post by your phones, and update as needed.

## **EMERGENCY MEDICAL SERVICES (EMS) INFORMATION**

Know how to contact your EMS. Most areas use 9-1-1; others use a 7-digit phone number.

- EMERGENCY PHONE NUMBER: 9-1-1 or \_\_\_\_\_
- Name of EMS agency \_\_\_\_\_
- Location of your program \_\_\_\_\_

## **BE PREPARED TO GIVE THE FOLLOWING INFORMATION AND DO NOT HANG UP BEFORE THE EMERGENCY DISPATCHER HANGS UP:**

- Name of caller \_\_\_\_\_
- Name of program \_\_\_\_\_
- Address and easy directions to your program \_\_\_\_\_  
\_\_\_\_\_
- Nature of emergency \_\_\_\_\_
- Exact location of injured or ill person \_\_\_\_\_
- Help already given \_\_\_\_\_
- Ways to make it easier to find you (standing in front of the building, red flag, etc.).

## **OTHER IMPORTANT PHONE NUMBERS**

Poison Control Center                      **1-800-222-1222** \_\_\_\_\_

DHS Child Care Licensing Representative    \_\_\_\_\_

Fire Department                              **9-1-1** or \_\_\_\_\_

Police    **9-1-1** or \_\_\_\_\_

Hospital    \_\_\_\_\_

Local Health Department                      \_\_\_\_\_



# **Chapter 7: Managing Childhood Illnesses and Infestations**





## Chapter 7: Managing Childhood Illnesses & Infestations

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## Daily Health Check

**Upon arrival** at the child care facility, each family will be greeted by a staff member who will spend a few minutes with the parent and child while **conducting a daily health check**. The caregiver should be at the child's level.

Here is a list of possible *visual signs* and symptoms to check:

- \_\_\_ Face and head (cuts, bruises, sore spots)
- \_\_\_ Eyes, ears, nose (redness, discharge, swelling, pain)
- \_\_\_ Hair (clean; check for lice or ringworm)
- \_\_\_ Arms and legs (cuts, bruises, burns, sores or wounds, pain)
- \_\_\_ Hands (sores, wounds, burns, unusual scars)
- \_\_\_ Feet (limping, pain, wounds, burns)
- \_\_\_ Skin (rashes, irritation, insect bites)
- \_\_\_ General appearance (body, hair and clothing clean; energy level; extreme hunger)
- \_\_\_ Obvious signs of illness (droopy appearance; listless; upset stomach)
- \_\_\_ "Hidden" areas (check for obvious signs of physical or sexual abuse during first bathroom break - bruising, pain during urination or bowel movement, bleeding)
- \_\_\_ Other \_\_\_\_\_

The tactile (*touch*) health check involves gently rubbing your hand on the child's back, shoulder, or head as you greet him or her. This is one way to observe signs of possible illness or injury on areas of the body which are covered by clothing or hair.

- \_\_\_ General feeling of warmth, indicating possible fever
- \_\_\_ Possible bruising or soreness; the child may flinch or pull away from your touch

**Verbal** communication as you greet each child may provide clues to possible illness or injury. Talk to child and ask questions such as:

- Did you get a good night's sleep?
- If an injury or apparent sore is observed, ask the child "How did you get hurt?"

Also communicate with the parent:

- Did child sleep normally?
- Is child eating and drinking normally? When was the last time child ate or drank?
- How did child seem to feel and act at home?
- Have any unusual events taken place?
- Have bowel movements and urine been normal? When was the last time child used toilet or diaper was changed?

Note (in writing) any evidence of illness or injury since child was last at child care. Discuss any concerns with parent and **keep a written record** of observation, date and time, and the discussion.

If a possible communicable disease is discovered during the Daily Health Check, the parent may be asked to take the child home.

**Recommendations for Exclusion**

Mild illness is common among children. Most children will not need to be excluded from their usual source of care for mild illnesses. Examples of **illnesses and conditions that do not require exclusion** include the following:

Symptoms	Management
Common cold	Use good hand hygiene at all times. Teach children to cover sneezes and coughs. Ventilate the facility with fresh outdoor air and maintain temperature and humidity.
Diarrhea (unless stool cannot be contained in diaper or if child is toilet trained and having accidents)	Use good hand hygiene at all times. Ensure children's immunizations are up to date. Use proper methods to cook and store food. Exclude for specific types of symptoms only. Use universal precautions with all children.
Rash without fever and without behavior change	Use good hand hygiene at all times. Exclude for specific types of symptoms only. Use universal precautions with all children.
Parvovirus B 19 infection (Fifth Disease)	Use good hand hygiene at all times. Exclude for specific types of symptoms only. Use universal precautions with all children.
Cytomegalovirus (CMV) infection	Use good hand hygiene at all times. Exclude for specific types of symptoms only. Use universal precautions with all children.
Chronic hepatitis B (HBV)	Use good hand hygiene at all times. Ensure all children's immunizations are up to date. Use universal precautions with all children. Do not permit the sharing of pacifiers or toothbrushes. Exclude for specific types of symptoms only.
Conjunctivitis without fever and without behavioral change (Pinkeye)	Use good hand hygiene at all times. Most children with pinkeye will get better after 5 or 6 days without antibiotics. Use universal precautions with all children. Exclude for specific types of symptoms only.
Human immunodeficiency virus (HIV)	Use good hand hygiene at all times. Use universal precautions with all children. Exclude for specific types of symptoms only.
Known methicillin-resistant Staphylococcus aureus (MRSA)	Use good hand hygiene at all times. Use universal precautions with all children. Avoid sharing personal items. Cover open or draining sores or wounds. Exclude for specific types of symptoms only.
Thrush ( white spots or patches in the mouth)	Use good hand hygiene at all times. Do not permit sharing of toothbrushes or pacifiers.

The amount of illness decreases after a child's first full year of attendance. Germs in early childhood programs are the same as those found in community outbreaks. The majority of infections are mild, self-limited, and require no treatment. Children attending early education or child care programs have fewer infections during their kindergarten year of school.

(Adapted from: Aronson, S. S., T. R. Shope, eds. 2013. Managing infectious diseases in child care and schools: A quick reference guide, 59-65. 3<sup>rd</sup> ed. Elk Grove Village, IL: American Academy of Pediatrics.)

### **Preparing for managing illness**

Caregivers should:

- a. Encourage all families to have a backup plan for child care in the event of short or long term exclusion.
- b. Review the inclusion and exclusion policies with families before enrollment. Clarify that the program staff, (not the families), will make the final decision about whether children who are ill may stay based on the program's inclusion and exclusion criteria and their ability to care for the child without compromising the care of other children in the program.
- c. Develop procedures for handling children's illnesses, including care plans and inclusion and exclusion policies. Consider asking a health professional (such as a public health nurse) to help you.
- d. Request a health care provider's note to readmit a child if needed to determine whether the child is a health risk to others, or if the health care provider's guidance is needed about any special care the child requires.
- e. Rely on the family's description of the child's behavior to determine whether the child is well enough to return, unless the child's status is unclear from the family's report.

### **Key criteria for exclusion of children who are ill:**

When a child becomes ill but does not require immediate medical help, a determination must be made regarding whether the child can remain in care, or should be sent home and temporarily "excluded" from child care. Most illnesses do not require exclusion. The caregiver should determine if the illness:

- a. Prevents the child from participating comfortably in activities
- b. Results in a need for care that is greater than the staff can provide without compromising the health and safety of other children
- c. Poses a risk of spread of harmful diseases to others

**If any of the above criteria are met, the child should be excluded, regardless of the type of illness.** The child should be removed from direct contact with other children and should be cared for in an area where the toys, equipment, and surfaces will not be used by other children or adults until after the ill child leaves and after the surfaces and toys have been cleaned and disinfected. The child will be cared for by a staff member known to the child until the parent arrives to take the child home.

**When a child requires exclusion the caregiver will:**

- a. Provide care for the child in a place where the child will be comfortable and supervised by someone who knows the child well and who will continue to observe the child for new or worsening symptoms.
- b. Document all signs and symptoms of illness including time and circumstances when symptoms appeared, temperature (if taken), and any changes in the child's condition. A potentially contagious child should be separated from other children by at least three feet. Each facility should have a predetermined physical location(s) where an ill child(ren) could be placed until care can be transferred to a parent or family member.
- c. Contact the family and ask that someone pick the child up as soon as possible once it is determined the child needs to be excluded.
- d. Discuss the signs and symptoms of illness with the parent who is assuming care. Review guidelines for returning to child care. If necessary, provide the family with written notes that may be given to the health care provider. The communication should include onset time of symptoms, observations about the child, vital signs and times (e.g., temperature 101.5°F at 10:30 AM) and any actions taken and the time actions were taken (e.g., one children's acetaminophen given at 11:00 AM). The nature and severity of symptoms and or requirements of the local or state health department will determine the necessity of medical consultation. Telephone advice, electronic transmissions of instructions are acceptable without an office visit.
- e. Follow the advice of the child's health care provider.

Contact the local health department if there is a question of a reportable (harmful) infectious disease in a child or staff member in the program. If there are conflicting opinions from different medical professionals about the management of a child with a reportable infectious disease, the health department has the legal authority to make a final determination.

- Document actions in the child's file with date, time, symptoms, and actions taken (and by whom); sign and date the document.
- In collaboration with the local health department, notify the parents of contacts to the child or staff member with presumed or confirmed reportable infectious disease.

The caregiver or the director at the early childhood program makes the final decision about whether a child meets or does not meet the exclusion criteria for participation and the child's need for care relative to the staff's ability to provide care.

Reportable conditions: The current list of infectious diseases designated as notifiable in the United States at the national level by the Centers for Disease Control and Prevention (CDC) are listed at [http://www.cdc.gov/osels/ph\\_surveillance/](http://www.cdc.gov/osels/ph_surveillance/).

**Resources**

1. Aronson, S. S., T. R. Shope, eds. 2013. *Managing infectious diseases in child care and schools: A quick reference guide*. 3rd ed. Elk Grove Village, IL: American Academy of Pediatrics.
2. Pickering, L. K., C. J. Baker, D. W. Kimberlin, S. S. Long, eds. 2009. *Red book: 2009 report of the Committee on Infectious Diseases*. 28th ed. Elk Grove Village, IL: American Academy of Pediatrics.

## Caring for Sick Children

### When children get sick after the daily health check

Young children enrolled in child care have a high incidence of illness such as upper respiratory tract infections, including ear infections and other temporary conditions such as rash, diarrhea and asthma that may not allow them to participate in the usual activities. Most child care settings will need to provide at least temporary care for ill children. If a child becomes ill during the day after the daily health check, providers can help manage the illness and keep the child comfortable until a designated adult arrives.

1. Monitor children for:
  - a. Participation in activities.
  - b. Need for additional care.
2. If participation decreases or need for care increases, then check for other symptoms.
3. If other symptoms are present:
  - a. Make a decision about exclusion.
  - b. Notify parent or designated family member.
  - c. Care for the child until parent or family member arrives.

### Basic issues for decision making:

- Set policies and know when to be flexible.
- Prepare families for inevitable illnesses ahead of time.
- Review the inclusion and exclusion criteria in the program's written policies with families upon enrollment.
  1. Make clear to family members that designated program staff members (not families) make the decision about whether children who are ill may stay.
  2. Such decisions are based on inclusion and exclusion criteria and the staff member's ability to care for the child who is ill without compromising the care of other children in the program.
- Develop procedures for handling children's illnesses, including care plans.
- Only ask for a health care provider's note to readmit a child if the health care provider's advice is needed to determine whether the child is a health risk to others or to provide information about special care the child requires.

### When you consider whether to keep a mildly ill child at your child care setting ask these questions:

- Do you have sufficient staff (including volunteers) to change the program for a child who needs some modifications such as quiet activities, staying inside or extra liquids?
- Are staff willing and able to care for a sick child (wiping a runny nose, checking a fever, providing extra loving care) without neglecting the care of other children in the group?
- Is there a small space where the mildly ill child can rest if needed?
- Are parents able or willing to pay extra for sick care if other resources are not available, so that you can hire extra staff as needed?
- Have parents made arrangements prior to illness for pick up and care of ill children if they are not available?

### Temperature tips

While you can tell if the child is warmer than usual by feeling his or her forehead, only a thermometer can tell if there is a fever. Even if the child feels warmer than usual, you do not need to check the temperature unless he or she has other signs of illness.

Always use a digital thermometer to check the child's temperature. Mercury thermometers should not be used. Temperature readings may be affected by how the temperature is measured and other factors.

Devices to measure body temperatures include thermometers intended for use in the mouth or armpit, and more recently developed devices that measure the temperature in the ear canal or the skin that overlies an artery next to the outside corner of the eye. The following 3 types of digital thermometers are listed below. While other methods for taking the temperature are available, such as pacifier thermometers or fever strips, they are not recommended at this time.

Type*	How it works	Where to take the temperature	Age	Notes
Digital multiuse thermometer 	Reads body temperature when the sensor located on the tip of the thermometer touches that part of the body. Can be used orally, or axillary.	Oral (in the mouth) Axillary (under the arm)	4 to 5 years and older Birth to 3 years Least reliable, technique, but useful for screening at any age	Label thermometer "oral" or "axillary". Don't use the same thermometer in both places. Taking an axillary temperature is less reliable. However, this method may be used in schools and child care centers to check (screen) a child's temperature when a child has other signs of illness. the temperature is used as a general guide.

Temporal artery



Reads the infrared heat waves released by the temporal artery, which runs across the forehead just below the skin.

On the side of the forehead

3 months and older  
Before 3 months, better as a screening device than armpit temperatures

May be reliable in newborns and infants younger than 3 months according to new research.

Tympanic



Reads the infrared heat waves released by the eardrum.

In the ear

6 months and older

- a. Not reliable for babies younger than 6 months.
- b. When used in older children it needs to be placed correctly in your child's ear canal to be accurate.
- c. Too much earwax can cause the reading to be incorrect.

Resources

1. <http://www.healthychildren.org/English/health-issues/conditions/fever/Pages/How-to-Take-a-Childs-Temperature.aspx> - How to Take a Child's Temperature
2. Aronson, S. S., T. R. Shope, eds. 2013. *Managing infectious diseases in child care and schools: A quick reference guide*. 3rd ed. Elk Grove Village, IL: American Academy of Pediatrics.
3. Health and Safety in the Child Care Setting: Prevention of Infectious Disease. A Curriculum for the Training of Child Care Providers – Module 1, Second Edition. Developed by The California Child Care Health Program 1322 Webster Street, Suite 402 Oakland, CA 94612-3218. June 1998.
4. Good Health Handbook: A Guide for Those Caring for Children, Oklahoma State Department of Health, Maternal and Child Health Service, 2011.

## Medication Administration

### Administration and storage of medication in child care

If you care for children, it is likely that you will care for a child with an acute or chronic health condition that requires giving medication. It is important to develop plans to assure that medications are given safely and stored correctly, and to seek advice when needed. All staff who work with children should have training on medication storage and administration practices as found through the American Academy of Pediatrics *Healthy Futures: Improving Health Outcomes for Young Children, Medication Administration in Early Education and Child Care Settings*. <http://www.healthychildcare.org/ParticipantsManual.html>

Medication should be given at home whenever possible, but there will be times when it must be given to the child while attending the child care program. Guidelines for each child care provider in Oklahoma must reflect current state regulations. Medications are given in child care to:

- a. Maintain the health of the child.
- b. Allow a child who is not acutely ill to attend the program.
- c. Comply with state and national laws, regulations, and best practice.

There are **three categories** of medications that are given to children in the child care setting:

Typical and routine medications	Medications for regular treatment of a chronic health condition	Emergency medications
Acetaminophen Ibuprofen Antibiotics	Asthma inhalers Insulin for children diagnosed with diabetes Medication for children diagnosed with seizures	Epinephrine auto injector for management of life threatening allergies Glucagon for management of severe low blood sugar Diastat for management of severe seizure

There are **three basic types** of medication:

Prescription	Over the counter	Non-traditional (alternative medicines)
Can only be prescribed by a health care provider such a M.D., D.O. Nurse Practitioner or Physician Assistant  Is dispensed by a licensed pharmacist	Can be purchased without a prescription and includes vitamins, acetaminophen, antihistamines, mild cortisone cream, or ibuprofen  Many do not have dosing information for children under the age of 24 months	Herbal (made from plants or plant parts) Homeopathic (made from plants, minerals, or animals)  These are purchased as over the counter medications without specific written orders from a health care provider.

All medications must be given according to the prescription or product label directions. Permission and instructions must be provided by the parent for each medication. Instructions should not conflict with the label directions and should be filed in the child's record.

The child care provider must have a plan in place to record administration of medication and to inform the parent of daily medication administration. When the medication is no longer needed, all remaining medication is returned to the parent.

**Resources**

American Academy of Pediatrics, Healthy Child Care American: Medication Administration in Early Education and Child care Settings, 2013. <http://www.healthychildcare.org/ParticipantsManual.html>

### **Key points for medication administration**

- **ALWAYS WASH YOUR HANDS BEFORE ADMINISTERING ANY TYPE OF MEDICATION!**
- Medication must be provided by the parent in the original container and clearly labeled with the child's name and directions.
- Medication is accompanied with written dated permission from the parent, giving the exact dosage and times to be administered.
- It is helpful to assign one person to give all medications to avoid omissions and duplications. The person who administers the medication should record the time given, initial or sign, and have the form readily accessible to parents.
- Make sure all medication brought to the child care facility has a label with the child's name, the date, and the name of the medication.
- Medication should only be administered to the child for whom it is intended.
- All medications are stored separately from food and kept in a safe place out of children's reach.
- Medication is either returned to the parent or disposed of properly when it is out-of-date or the child has withdrawn from the facility.

### **Safeguards to prevent errors**

- Consult with the parent, pharmacist or health care provider if uncertain about the next dose.
- Assign a staff member to administer medications at the right time.
- If a medication is crucial and was left at home, ask the parent to return home and get medication before the child is admitted for the day.
- Establish a system to ensure that medications are returned each day for the family to use at home. (Some pharmacies will divide the prescription into two containers – one for home and one for child care or school.)
- Develop a system to alert staff members that a child has medication.
- Use measuring devices such as medicine caps or oral syringes for liquid medications, rather than household utensils.
- If a medication error is made, notify the parent immediately and consider seeking advice from the child's pharmacist or health care provider. Also fill out a Medication Incident Report.

### Remember the Five R's

1. **Right child** – check the name on the medication label to be sure the name on the label is the name of the child receiving the medication.
2. **Right medication** – read the label when receiving the medication and read it again when measuring out the medication for the child.
3. **Right dose** – read instructions for amount of dosage, and measure with an accurate measuring device.
4. **Right route** (*mouth, nose, ears, airway, etc.*) – read label and instructions to verify the route. For example; ointments and drops can go in the nose, ears, or eyes.
5. **Right time** – read instructions for time of administration of medication. Check with parent to see when the last dose was given to be sure when the next dose is due.

### Always check:

- **Parental Permission** - must be in writing and filed in child's record.
- **Medication Label** – must have the child's name, dosing instructions, special instructions.
- **Parent Notification** – use standard form to notify parents of medication given.
- **Allergies and Reactions** – check before giving medication if the child has allergies and watch for reactions afterward.

### Contact the child's parent if:

- The child vomits the medicine.
- You are unable to get the child to take the medicine, or are unable to administer the medication.

The parent will probably need to contact the child's health care provider.

**Remember that when you administer medication, you are accepting responsibility for knowing the appropriate actions to take if a major adverse reaction occurs. It is a good policy to require parents to administer the first dose of a new medication at home so they will be aware of the child's reaction.**



## Bedbugs

### What are bedbugs?

Bedbugs are small, oval-shaped, wingless, brownish, flattened insects that feed on human blood by biting through the skin. They get their name because they like to live and feed in beds, mainly at night.

### What are signs or symptoms?

- Itchy insect bites that often occur in a row, on areas of skin that are exposed during the nights.
- Bites often have a red dot where the bite occurred in the middle of a raised red bump.
- Bites typically occur on face, neck, arms, and hands.
- Look for specks of blood, rusty spots from crushed bugs, or dung spots the size of a pen point on bedsheets and mattresses.
- Look for reddish/brown live bugs, about 1/8 of an inch, in crevices or seams of bedding.

### Are they contagious – how are they spread?

- Bedbugs do not reproduce on humans like scabies or lice. They bite humans at night, and hide in cracks or crevices on mattresses, cushions, or bed frames during the day.
- Children or staff may bring bedbugs to school in book bags, backpacks and clothes.
- Bedbugs do not spread on people – they are not a sign that people are dirty. They feed on people and may hide in their belongings or clothing and that is a way they may spread to others in a group care setting.

### How do you control them in a group setting?

- Avoid overreacting. One bedbug is not an infestation. It is not necessary to send a child home.
- Educate staff members and families about bedbugs.
- Reduce clutter and limit items that travel back and forth between homes and the facility.
- Seal cracks. Clean up any bedbug debris with detergent and water.
- Provide enough space between coat hooks so each child's belongings do not touch those of another child.
- Empty and clean cubbies, lockers, and child storage areas at least once every season.
- Extermination involves vacuuming and one of the following approaches:
  - Application of the least toxic products (preferably bio-based).
  - Heat the living area to 122 degrees for about 90 minutes.
  - Freeze infested articles, or (if necessary) use synthetic chemical insecticides.
- Launder bedding and clothing (hot water and hot drying cycle for 30 – 60 minutes).
- Vacuum with special attention to cracks and crevices in furniture, equipment, walls, and floors. Dispose of the vacuum cleaner filter and bags in a tightly sealed plastic bag.



## **Campylobacter**

### **What is it?**

Campylobacter infection is a contagious disease caused by bacteria. The intestinal infection usually causes diarrhea.

### **What are the signs or symptoms?**

- Major symptom is diarrhea
- Stomach cramps
- Fever
- Nausea and vomiting
- Generally “not feeling well”

The bacteria can be identified through a stool culture.

### **How long does it take from exposure to development of Campylobacter?**

Symptoms usually start two to five days after infection.

### **When is it contagious?**

Campylobacter infections should be considered contagious from a few days to several weeks, after being infected.

### **How is it spread?**

Eating food or drinking water, contaminated by the feces (stool) of infected people or animals (fecal-oral), spreads the bacteria. Hand washing before and after food preparation limits this kind of spread.

### **What should be done?**

- Isolate the child if there is diarrhea with illness, fever, or vomiting, or if the stool is not contained in the diaper, or is causing toileting accidents.
- Notify the parents to pick up the child.

### **When can the child be re-admitted?**

The child can be readmitted upon approval from health care provider or the local health department.

### **What can be done to prevent the spread of Campylobacter?**

- Wash hands properly with soap, after each diaper change and bathroom use.
- Clean all diaper changing surfaces with soap and water, then disinfect with a U.S. Environmental Protection Agency (EPA) registered disinfectant, such as a bleach solution.
- Teach children to wash hands.
- Always refrigerate meat products.
- Carefully wash hands before and after preparing foods.

**Who should be notified?**

Notify the local health department. They will provide you with further information.

## **Chickenpox**

### **What is it?**

Chickenpox is a contagious disease caused by the Varicella-Zoster virus.

### **What are the signs or symptoms?**

The four stages of the rash are:

- A red bump
- A clear blister appears on top of the bump
- The clear blister becomes a pustule (its content becomes gray)
- The pustule dries into a crust

They appear in crops, over a period of up to four days. Several stages may be present at the same time. The child may have bumps, blisters, and pustules up to four days. They may leave permanent scars, especially if the blisters get infected by bacteria. Fever can be anywhere from none to very high, and may appear a few days before the rash.

### **How long does it take, from exposure to development of the disease?**

Two to three weeks.

### **When is it contagious?**

From five days before the rash appears until six days after the appearance of the first crop of blisters, or until the spots are all dried and crusted, whichever is longer.

### **How is it spread?**

The virus is spread by droplets from the nose, mouth or throat, usually expelled by a cough or sneeze. It can also be spread by direct contact, such as eating, drinking, or sharing personal items, or from the fluid from the blisters of an infected child (respiratory and direct contact spread). The scabs are *not* contagious.

### **What should be done?**

- Isolate the child from the other children.
- Notify the parents to pick up the child.
- Wash articles soiled by discharge from the nose, throat, and blisters.

- Watch closely for early symptoms in others for up to three weeks.

**When can the child be re-admitted?**

The child can be readmitted six days after the appearance of the first crop of blisters, or when all blisters are scabbed over and dry.

**What can be done to prevent the spread of Chickenpox?**

- *Make sure all children have received the Varicella vaccine between 12 and 15 months.*
- Anyone coughing or sneezing should cover his or her nose and mouth.
- Do not allow eating or drinking after others.
- Careful hand washing may help prevent the spread.

## **Common Cold (Upper Respiratory Infections)**

### **What is it?**

The common cold is a mild infection of the upper respiratory tract (nose, throat, ears, and eyes) which is caused by over 100 different types of viruses. The most common of these is the rhinovirus (nose virus).

### **What are the signs or symptoms?**

Runny or stuffy nose, sneezing, coughing, watery eyes, mild sore throat, and sometimes chills and fever.

### **How long does it take from exposure to development of a cold?**

Between 12 and 72 hours.

### **When is it contagious?**

For about two days before symptoms begin and during the first five days of illness.

### **How is it spread?**

Colds are spread by coughing and sneezing and by contact with contaminated hands, tissues, and other articles soiled by nose and throat discharge (respiratory and direct contact spread).

### **What should be done?**

- No specific treatment is available. Nothing can shorten the duration of a cold.
- Ibuprofen or Acetaminophen-containing medications should be used only if the child has a fever, sore throat, or muscle aches, and you have written parental permission.
- **Do not give Aspirin.** Aspirin appears to increase the risk of Reye's syndrome; a serious disorder characterized by sleepiness and vomiting that can lead to coma and death.

### **Should people with this illness be excluded?**

There is no need to exclude these children and staff if they feel well enough to attend and do not require more care and attention than the program can provide.

### **What should be done to prevent the spread of the common cold?**

- Make sure all children and staff use good hand washing practices.
- Wipe noses with clean tissues, dispose of them properly and wash your hands.
- Don't share food, cups, bottles, or toothbrushes.
- Don't kiss children on the mouth.
- Teach children to cough into their elbow and away from people.
- Open windows and maximize outdoor play.
- Keep the environment clean.
- Limit physical contact between young infants and infected children.

### **Who should be notified?**

Because the common cold is very common and is not considered dangerous, it is not necessary to notify all parents of every exposure.



## Conjunctivitis (Pink Eye)

### What is it?

Conjunctivitis or pink eye is a common, mild eye infection or irritation. It can be caused by germs (infectious conjunctivitis) and often occurs with a cold or ear infection. Allergies, chemicals or irritants can also cause it.

### What are the signs or symptoms?

- It involves one or both eyes and usually lasts three to five days.
- The white parts of the eyes become pink and the eyes produce lots of tears and discharge.
- Eyes can be itchy, sore, and sensitive to light.
- In the morning the discharge may make the eyelids stick together. Bacteria usually cause thick yellow or green pus.

### How long from exposure until the disease develops?

One to three days.

### When is it contagious?

As long as discharge is present, the child should be considered contagious.

### How is it spread?

*It is spread by direct contact.* Children often pass the infection by rubbing their eyes then touching someone or something. Conjunctivitis can also be spread when staff wash, dry, or wipe a child's face and then use the same washcloth on another child's face.

### Exclude from group setting?

*No, unless:*

- The child meets other exclusion criteria, such as fever or behavior change.
- The child is unable to participate and the caregiver cannot care for the child without compromising the health and safety of the other children.

### What should be done?

- Notify parents if child develops a fever and is unwilling to participate in activities. Encourage a visit to the child's health care provider.
- Practice frequent hand washing, especially when wiping a child's face or eyes.
- If the disease is determined to be bacterial in origin, the other parents should be notified that pink eye has occurred and encourage them to watch closely for signs of the illness in their children.

### When can the child be re-admitted?

- When exclusion criteria are resolved and the child is able to participate in activities.
- For bacterial conjunctivitis – 24 hours after antibiotic treatment has begun.

### What can be done to prevent the spread of pink eye?

- Encourage the child not to rub his or her eyes.

- Keep children's eyes wiped free of discharge and always wash your hands after wiping a child's eyes.
- Use disposable tissues and towels.
- Teach children to wash their hands after wiping their eyes.

## **Cradle Cap (Seborrhea)**

### **What is it?**

- Cradle Cap is an oily, yellow scaling or crusting on the scalp.
- It is common in babies and is easily treated.
- It most often affects the scalp, but can also occur on the forehead, eyebrows, and the creases behind the ears.
- Cradle cap is not part of any illness and does not imply that a baby is not well cared for.

### **What causes cradle cap?**

Cradle cap is the normal buildup of sticky skin oils, scales, and sloughed skin cells.

### **How is cradle cap treated?**

Home treatment is usually all that is needed.

- An hour before shampooing, rub baby's scalp with baby oil, mineral oil, or petroleum jelly to help lift the crusts and loosen scales.
- When ready to shampoo, first wet the scalp, and then gently scrub the scalp with a soft-bristle brush (a soft toothbrush works well) for a few minutes to remove the scales. You can also try gently removing the scales with a fine-tooth comb.

Then wash the scalp with baby shampoo, rinse well, and gently towel dry.

### **When is it time to contact a health care provider?**

If the above measures do not work, talk to a health professional before using a dandruff shampoo, such as *Selsun Blue*, *Head and Shoulders*, or *Sebulex*. If these products get in your baby's eyes, they can cause irritation. The health care provider may prescribe other medications.

**Cradle cap is not harmful to baby and usually goes away by baby's first birthday.**



## **Cytomegalovirus (CMV)**

### **What is it?**

Cytomegalovirus (CMV) is a common virus that infects most people at some time during their lives but rarely causes illness.

### **What are the signs or symptoms?**

Most children and adults who are infected with CMV do not become ill. Those who do may have fever, swollen glands, and feel tired. Immuno-compromised people (such as AIDS patients or those receiving cancer treatments) may have a more serious illness such as pneumonia.

### **How long does it take from exposure to development of the disease?**

CMV may remain in the body throughout the person's lifetime. The virus may be found in the urine or saliva of infected people who may or may not be ill. The person is contagious as long as the virus is shed.

### **How is it spread?**

CMV is spread from person to person by direct contact. It can be found in the urine, saliva, breast milk, blood, semen, and possibly in other body fluids. The virus can spread from an infected mother to her fetus or newborn baby. Children aged one to three years shed CMV in highest rates.

### **What is the treatment for CMV infections?**

There is usually no treatment for CMV infections.

### **Should an infected person be excluded from school or work?**

There is no reason to exclude a child from care because the program probably has other children and also staff who have CMV.

### **What precautions should pregnant women take?**

Pregnant women should carefully wash their hands after handling wet diapers or having contact with urine or saliva. CMV can cause problems for pregnant women. If a woman gets CMV for the first time, while pregnant, the risk of disease in the fetus is greater. Young women who may be or may become pregnant should ask their health care provider about CMV. It is recommended that pregnant staff members not work in classrooms with young children still in diapers.

### **What can be done to prevent the spread of CMV?**

- Good hand washing is the best way to prevent infection with CMV.
- Disinfect toys and surfaces in toddler and infant rooms daily or more frequently, if needed.



## Diarrhea

### What is it?

Diarrhea is an illness in which someone develops more watery and frequent stools than is typical for that person. Diarrhea can be caused by changes in diet, an allergy to certain foods, food poisoning, emotional upset, or the use of some medications. Sometimes diarrhea is a contagious disease caused by a virus, bacteria, or parasite.

### What are the signs or symptoms?

- Frequent loose or watery stools
- Abdominal cramps and tenderness
- Fever
- Generally not feeling well
- Blood in stool

Following are some of the organisms known to cause diarrhea:

<ul style="list-style-type: none"><li>• Rota-Virus</li><li>• Norwalk Virus</li><li>• Hepatitis A Virus</li><li>• Salmonella</li><li>• Giardia</li></ul>	<ul style="list-style-type: none"><li>• Shigella</li><li>• Campylobacter</li><li>• Clostridium Difficile</li><li>• E-coli</li></ul>
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### How long does it take from exposure to development of disease?

After exposure, another person may develop diarrhea from one day to weeks later, depending on the specific infection.

### When is it contagious?

Most infectious diarrhea caused by a virus is contagious one to two days before the start of symptoms and may continue to be contagious for a few days after the diarrhea has ended. Diarrhea should always be considered contagious until a health care provider determines that it is not.

### How is it spread?

- Diarrhea is spread by the fecal-oral route. Fecal-oral means the germs in one person's bowel movement wind up in another person's mouth, usually by way of unwashed hands.
- Water or food contaminated by human or animal feces.
- Contact with raw or undercooked poultry.
- Contact with animals in the child's environment or during trips to sites with animals.

### Exclude from group settings if:

- Stool is not contained in the diaper, or diarrhea is causing accidents for children who don't wear diapers.
- Stool frequency exceeds two or more above normal for that child.
- Stool is all black, or there is blood or mucus in stool.

### **What should be done?**

- Notify the parent of the child.
- The most important treatment for a young child with diarrhea is to replace fluids.
- With the first signs of diarrhea, the child should be encouraged to drink small amounts of clear fluids frequently.
- If the child has other signs of illness, such as fever or vomiting, or the diarrhea is frequent and the child is less than two years old, have the parent contact the child's health care provider for specific recommendations.
- If the child has an appetite it is advisable to offer a normal diet but provide extra fluids.
- **If the onset is abrupt and the diarrhea is severe with evidence of blood or high fever, an immediate visit to the child's health care provider is necessary.**

### **When can the child be re-admitted?**

- Once stool frequency has reduced to fewer than two stools above normal for that child, even if the stools remain loose.
- Once diapered children have their stool contained by the diaper and when toileting children do not have toileting accidents.
- Once child is well-hydrated.
- When the child is able to participate and staff members determine they can care for the child without compromising their ability to care for the health and safety of the other children in the group.

### **What can be done to prevent the spread of diarrhea?**

1. Hand washing is the most important line of defense for both caregivers and children in preventing the spread of diarrhea. Staff and children wash their hands:
  - Upon arrival at the child care facility.
  - After returning from playing outdoors.
  - After using the toilet or helping a child use the bathroom.
  - After each diaper change.
  - Before and after preparing, serving, or eating food.
2. Disinfect toys, bathrooms and food preparation surfaces daily.
3. Use disposable paper towels for hand washing.
4. Use disposable table liners on changing tables and wash and disinfect tables after each use.

### **Who should be notified?**

- Notify parents of children who have been in direct contact with a child who has diarrhea. Parents should contact their child's health care provider if their child develops diarrhea.
- Notify the local health department if two or more children in one child care facility have diarrhea within a 48-hour period.
- Also notify the local health department if you learn that a child in your care has diarrhea due to *Shigella*, *Campylobacter*, *Salmonella*, *Giardia*, *Cryptosporidium*, or *E coli*. A health care provider or public health official must clear the child for readmission in these cases.

## Diphtheria

### What is it?

Diphtheria is a serious bacterial disease which is spread person to person by infected secretions. Diphtheria causes inflammation of the throat, nose and tonsils, and a high fever. It can interfere with swallowing and cause blockage of the airway, making it impossible to breath. It frequently causes heart and nerve problems.

In the 1920's, diphtheria was a major cause of illness and death for children in the U.S. Although it is rare in the U.S. today, it appears that the diphtheria bacteria continue to pass among people. Diphtheria is common in other parts of the world. With the increase in international travel, diphtheria and other infectious diseases are only a plane ride away.

### What are the signs or symptoms?

- The symptoms of diphtheria vary depending on what part of the body is infected.
- The most common infection occurs in the throat and tonsils causing symptoms from a slight fever, chills, and sore throat to a severe feeling of general illness.
- Other symptoms which might occur include hoarseness, barking cough, runny nose, scaly rash, and open skin sores.

### When is it contagious?

Usually an infected person is able to spread diphtheria for two to four weeks after symptoms develop. The rare chronic carrier (a person with continual infection) may be infectious for six months or longer.

### How is it spread?

Diphtheria is spread through the air from the mouth, throat, or nose of an infected person through coughing or sneezing. Rarely, diphtheria is spread by contact with articles soiled with discharges from skin sores of an infected person.

### What should be done?

- Antibiotics and antitoxin are used to treat diphtheria.
- The patient may also need help in breathing.
- Often the patient should be isolated.
- People who live in the same household as a person with diphtheria and people who have close, habitual contact with a diphtheria patient should receive treatment.

### When can the person be re-admitted?

The person can return to the program after being treated, with permission from a health care provider.

### What can be done to stop the spread of Diphtheria?

The best way to **stop the spread of diphtheria** is to **immunize**:

- A child needs 4 doses of DTaP (diphtheria, tetanus, pertussis) vaccine by two years old.
- A child should receive a DTaP booster sometime between four and six years old.
- A child should receive a Tdap booster sometime between 11 to 12 years old.

- Td (tetanus and diphtheria) is recommended for all adults every 10 years.
- One dose of Tdap should be substituted for one dose of Td for adults.

**Who should be notified?**

Notify your local health department if someone in your program has this disease. They will provide you with further information.

## Ear Infection (Otitis Media)

### What is an ear infection?

Infection of **the middle ear**, or *otitis media*, is an infection of the part of the ear behind the eardrum.

- It is usually a complication of an upper respiratory infection, such as a cold.
- It can be acute (new), chronic (persistent), or serious (associated with fluid that does not contain germs).
- Otitis media is more common in young children because the tube that connects the middle ear to the nasal passages is very short and straight, making it easy for bacteria in the mouth and nasal passages to reach the inner ear.
- Most ear infections are caused by bacteria.

### What are the signs or symptoms?

- Pain inside the ear or when moving the earlobe
- Repeated tugging at the ear
- Irritability or fussiness
- Crying
- Poor feeding
- Disturbed sleep
- Fever
- May have ear drainage

### Who gets it and how?

- Middle ear infections are common in children between the ages of one month and six years, and most common under age three.
- Some children develop ear infections a few days after a cold starts.
- Conditions that increase a child's risk of ear infections are:
  1. Frequent colds
  2. Bottle propping
  3. Exposure to smoke
  4. Attendance in a child care program.

### Effects of ear infections

- If an ear infection does not clear up quickly, or does not respond to treatment, a temporary hearing loss can occur.
- A hearing loss for only two or three months may impair a child's language and learning.
- A ruptured eardrum or other serious complications can also occur.
- The age of birth to three years is a very important period of development.
- A child that has many ear infections may hear muffled speech.
- This may affect his ability to repeat sounds and words in order to learn normal speech and may delay language development.

**Other signs**

- A child frequently doesn't look up when someone enters the room.
- The child doesn't hear you call, but a nearby friend does.

**Exclude from group setting?**

Since ear infections themselves are not contagious, there is no reason to exclude a child with one from your program unless they have a high fever or cannot participate in activities because of pain.

**How to prevent ear infections**

- Prevent the spread of colds and other upper respiratory infections which may lead to otitis media.
- Breastfeeding reduces the number of ear infections so remember to support your breastfeeding moms.
- Make sure all children and staff use good hand washing practices.
- Don't allow children to share food, utensils, or toothbrushes.
- Wash toys regularly, especially the ones that young children put in their mouths.
- Do not bottle-feed infants lying on their backs. Keep infants upright or inclined while feeding. The liquid can back up into the Eustachian tube, creating a breeding ground for bacteria.
- Provide a smoke-free environment.

**Be alert for any sign of hearing or speech problems that may develop. Refer the child to his or her health care provider.**

## **Ebola**

### **What is it?**

Ebola is a serious illness caused by infection with the Ebola virus. It is a severe, often fatal disease in humans and non-human primates (such as monkeys, gorillas, and chimpanzees).

### **What are the signs or symptoms?**

- Fever
- Severe headache
- Muscle pain
- Vomiting
- Diarrhea
- Stomach pain
- Unexplained bruising or bleeding

### **How long does it take from exposure to development of the illness?**

Symptoms may appear anywhere from 2 to 21 days after exposure, although 8 to 10 days is most common.

### **How is Ebola Spread?**

Ebola virus is spread through direct contact with the blood or body fluids (including but not limited to feces, saliva, sweat, urine, vomit, breast milk, and semen) of a person who is sick with Ebola. The virus in blood and body fluids can enter another person's body through broken skin or unprotected mucous membranes in, for example, the eyes, nose, or mouth.

- Ebola virus is not spread through air or by water, or by any food grown or approved for consumption in the United States.
- You cannot be infected by someone who has been exposed to Ebola but does not have symptoms.

### **Who is at Risk?**

Health workers and the family and friends in close contact with Ebola patients are at highest risk because they may come in contact with the blood or body fluids of sick patients while caring for them.

**Children are at greater risk from seasonal influenza (flu) than they are from the Ebola virus.**

### **What Can Child Care Providers Do to Help?**

**Prevention:** Child care providers should continue to use good infection control practices. The same steps that prevent the spread of many other diseases help to prevent Ebola transmission:

- Wash hands often with soap and water for 20 seconds.
- Avoid touching eyes, nose and mouth with unwashed hands. Avoid close contact such as kissing, hugging, and sharing cups or eating utensils with people who are sick.

- Proper cleaning of equipment, toys, and surfaces such as countertops, doorknobs, sinks, and toilets help to prevent the spread of illnesses.
- Child care providers should separate soiled bedding from cribs, mats, cradles, or cots from other used laundry to avoid contamination. Soiled bedding should be washed separately using regular “hot” or “cold” washing cycles and regular drying cycles.
- Child care providers should wear gloves in cases where they may come into contact with blood or body fluids (e.g., treating a scrape or changing a diaper), and these gloves should be removed and disposed of properly to avoid contact. After removing gloves, staff should wash their hands again.
- Child care providers should follow their standard protocols for dealing with sick children. Children with a fever, vomiting, or diarrhea should remain home until they no longer have symptoms.
- Providers can also help by sharing prevention information with the families they serve.
- **Support Child Care Staff:** In the unlikely case that center-based staff had contact with an Ebola patient, these employees may be asked by public health authorities to stay at home for 21 days. Providers should review their staffing plans to ensure adequate coverage, if needed. In the unlikely case that home-based providers have had contact with an Ebola patient and are asked by public health authorities to remain at home, they should refrain from caring for children during this period.

**Reduce Stigma:** Stigma can occur when people link a disease with a certain group of people, even though not everyone in that group is at risk for the disease. Children and families are not a threat simply because they have connections to West Africa. Remember – Ebola is caused by a virus – not a person – and the virus is difficult to transmit.

Child care providers that serve families with ties to West Africa can be helpful as a source of support and community connection. All people who have traveled to an affected country or may have had exposure to an Ebola patient should be undergoing monitoring with support of their local public health department. Providers can support families undergoing monitoring and encourage them to call the local health department if they begin showing any symptoms, such as an elevated fever.

In the unlikely case that a child or staff member is asked by public health authorities to remain at home, providers should stress that if individuals do not develop Ebola symptoms during the 21-day monitoring period they do not have Ebola and pose no risk when they return afterwards.

**Reduce Children’s Fears:** Even young children may be exposed to media reports or overhear adults discussing Ebola. These steps may help child care staff support children who are coping with Ebola-related fears

- Be cautious about discussing Ebola where children may overhear. Limit children’s exposure to media reports on the disease.
- If children have questions, make time to listen to their concerns and answer their questions.
- Be honest. Answer questions based on the facts.

- Speak in a calm tone of voice. Use reassuring words and remind children their parents, providers, and other adults in their life are working together to keep them safe and healthy.
- Keep all explanations age-appropriate.
- Be clear about the differences between images they may have seen of West African countries and the situation in the United States.
- Reinforce hand washing and other disease prevention steps that children can take themselves. Good hygiene steps are not only beneficial for children's health, they also help children feel empowered and able to make a difference.

### **Support is Available for Providers and Parents, Too**

Child care providers and parents may feel stress or worry associated with Ebola, especially if there are cases identified in their communities. Immediate, confidential, and free crisis counseling is available to people concerned about Ebola virus reports through the [Disaster Distress Helpline](#) (1-800-985-5990 and TTY for Deaf individuals: 1-800-846-8517). [Tips on Coping with Stress during Infectious Disease Outbreaks](#) are also available online.

This information is from the Office of Human Services Emergency Preparedness and Response at the Administration for Children and Families, U.S. Department of Health and Human Services.



### ***E. coli (Escherechia coli)*, Toxin-producing**

Also called Shiga toxin-producing *E. coli* (STEC), *E. coli* O157:H7, *E. coli* O111, etc.

**What is it?** Many forms of *E. coli* are harmless and part of normal intestinal bacteria. Some types, called STEC, can cause mild to severe disease. It can even affect the kidneys and other organs.

**What are the signs or symptoms?** The symptoms are mild to severe diarrhea, which may be watery or bloody.

**How is it spread?** *E. coli* is in the stool (feces) of animals and people who are ill. Animals that can carry it without having symptoms include certain farm animals (cows, sheep, goats or deer).

**How long does it take from exposure until the disease develops?** The time ranges from 2 to 10 days, usually 3 to 4 days.

**When is it contagious?** It can be spread in the feces until up to three weeks after diarrhea starts in children (usually one week in adults). It is very easily spread within households, in child care settings, and in group living facilities.

**What should be done?** When a child has diarrhea, remove him or her from contact with others and call the parents to take the child home when:

- Stool is not contained in the diaper, or diarrhea is causing accidents for children who don't wear diapers.
- Stool frequency exceeds two or more above normal for that child.
- Stool is all black, or there is blood or mucus in stool.

If diarrhea persists, the child should be taken to see a healthcare provider.

**How is it treated?** There is not a specific medication to treat *E. coli* infections, but fluids and other supportive care will help the person recover.

**When can the child be re-admitted?** When a laboratory confirms one of the STEC types of *E. coli* in a patient, the health department is notified. The health department then works with the parent to determine when it is safe for the child to return. The child should be free of diarrhea for at least 24 hours, plus have two lab tests that are negative for STEC before returning to the child care setting.

**What can be done to prevent the spread of *E. coli*?**

- Focus on thorough hand hygiene at appropriate times for children and employees.
- Supervise children in hand washing after using the bathroom and before meals.
- Eliminate access to shared water play areas.
- Follow safe food handling practices.
- Clean and disinfect diaper-changing surfaces after each use.

**Who should be notified?** Certain types of *E. coli*, specifically the ones causing STEC will be reported to the health department, and an investigation will take place. If you have a question about a child's illness, contact the Acute Disease Service Epi-on-call at 405-271-4060 to discuss the situation and determine any recommendations.

## Fever

### What is fever?

A fever is an elevation of the normal body temperature. Fever is most commonly the body's natural response to an infection caused by virus or bacteria.

It is generally accepted that a temperature of **100.4 degrees F or more in a young infant** or **101 degrees F in older infants and children** is *a fever* no matter what method you use to take it.

### Factors that can cause a mild elevation in body temperature

- Exercise – including active play and exertion
- Time of day (late afternoon)
- Teething
- Environmental temperature caused by –
  - A hot room
  - A hot day
  - Child bundled up excessively

*These factors do not represent a true fever.*

### Other signs of fever

- The skin appears flushed.
- Fatigue – child is tired and listless.
- Child is irritable.
- Child has a decreased appetite.
- A child's forehead or abdomen may feel quite warm, but taking the temperature is the only way to know for sure if there is a fever.

### The Do's and Don'ts for a child who has a fever

- **DON'T** use ice packs or alcohol rubs. These can bring the fever down too quickly and cause problems. These methods are also very uncomfortable for a child.
- **DO** use lukewarm water to cool him or her down if the child is uncomfortable. Offer cool fluids, popsicles or slushies made with crushed ice and clear 100 percent juice.
- **DON'T** give aspirin to children under the age of 12 years unless prescribed by a health care provider. Aspirin in children is associated with a sometimes deadly disease called Reye's syndrome.
- **DO** give Tylenol or Motrin if you have a medication administration policy, written parental permission, and written instructions from the health care provider. These medications generally help bring the fever down within 20 to 40 minutes.
- **DON'T** bundle children up in blankets or heavy clothing.
- **DO** allow children to cool down more easily with light clothing and covers.

**When should a child with a fever be excluded from child care or sent home?**

- If fever is noted in an infant younger than two months.
- If fever is associated with behavior change or other signs of illness.
- If the child is unable to participate and staff members determine they cannot care for the child without compromising their ability to care for the health and safety of the other children in the group.

**What can be done to prevent the spread of the fever?**

- Make sure all children and staff use good hand washing practices.
- Teach children to wash their hands after blowing their nose or coughing.
- Keep the environment clean.
- Do not allow sharing of mouthed toys, bottles, cups or pacifiers.
- Clean and disinfect toys and hard surfaces frequently. Mouthed toys should be cleaned and sanitized after each use, or removed until cleaning takes place.
- Open windows and maximize outdoor play.

## **Fifth Disease**

### **What is it?**

Fifth Disease is a contagious disease spread by a virus and it's also known as "Slapped Cheek." It is usually a mild rash illness of children. There is some risk to unborn babies, so if a pregnant woman is exposed to Fifth Disease she should consult her health care provider.

### **What are the signs or symptoms?**

- A red rash that generally appears on the face giving a "slapped face" appearance.
- A low-grade fever.
- Rash may spread to the rest of the body.

### **How long does it take from exposure to development of Fifth Disease?**

One to two weeks, but it may be that the first symptom will be the rash in two to three weeks.

### **When is it contagious?**

People with Fifth Disease can spread the illness during the week before the rash appears. By the time the rash is seen, the virus can no longer be spread to others.

### **How is it spread?**

The virus is spread by contact with airborne droplets produced by coughing or sneezing. These droplets may be inhaled by someone or touched by another person who then takes the droplets into their mouth.

### **What should be done?**

There is no treatment and this is usually a mild illness. Treatment may be given to relieve some symptoms such as itching or fever.

### **When can the child be re-admitted?**

The child does not need to be excluded, because by the time the rash appears, it is no longer contagious.

### **What can be done to prevent the spread of Fifth Disease?**

- Make sure all children and staff use good hand washing practices.
- Keep the environment clean.
- Do not allow sharing of mouthed toys, bottles, cups or pacifiers.
- Clean and disinfect toys and hard surfaces frequently. Mouthed toys should be cleaned and sanitized after each use, or removed until cleaning takes place.
- Make sure the facility is well ventilated. Open windows and maximize outdoor play.

### **Who should be notified?**

Notify parents of the child, as well as other parents and staff members. Pregnant women and parents of children who have a weakened immune system may want to consult their health care provider.



## **Flu (Influenza)**

### **What is it?**

The flu is a contagious disease caused by a group of respiratory viruses called influenza viruses. The flu mainly affects the respiratory tract (nose, throat, and lungs).

### **What are the signs or symptoms?**

*Symptoms of the flu include:*

- Sudden onset of fever
- Headache
- Chills
- Muscle aches and pains
- Sore throat
- Nasal congestion
- Cough
- Decreased energy
- Abdominal pain
- Croup, bronchiolitis, or pneumonia

### **How long does it take from exposure until the disease develops?**

Usually one to five days after exposure.

### **When is it contagious?**

It can be spread from the day before symptoms begin, to four days afterwards.

### **How is it spread?**

- It is spread when someone with the flu coughs, sneezes, or does anything that releases the nose and throat secretions outside their body.
- This can directly spread from one person to another, or someone can touch a surface or object that has been coughed on, and infect themselves by touching their eyes, noses or mouths.

### **What should be done?**

When a child develops these symptoms, remove him/her from contact with others and call the parents to take the child home. If the symptoms continue at home, the child may need to be taken to see a health care provider.

### **How is it treated?**

In certain circumstances, antivirals (NOT ANTIBIOTICS, which only treat bacteria) are prescribed by a health care provider.

### **When can the child be re-admitted?**

The child can return when the fever has gone away for 24 hours without the use of any fever-reducing medication, and the other symptoms have improved enough that the child can participate in the usual activities.

### **What can be done to prevent the spread of flu?**

*These actions are all important in preventing the spread of flu:*

- Encourage **annual flu vaccination of children and employees**, which prevents the flu in most cases. Even if the flu still happens, it is usually a much milder illness.
- Focus on thorough hand hygiene at appropriate times for children and employees.
- Teach children and employees to “Cover Your Cough” using a tissue (followed immediately by hand hygiene) or by covering their coughs or sneezes with their sleeves.
- People with flu symptoms should stay home until the fever has gone away for 24 hours without the use of any fever-reducing medication, and the other symptoms have improved enough to return to general activities.

### **Who should be notified?**

The flu in just one person is not reportable to the state health department, but if even a small a group of people (children and/or adults) have the flu or symptoms of the flu near the same time, contact the Acute Disease Service Epi-on-call at 405-271-4060 to discuss the situation and determine any recommendations.

**Comments:** Flu can spread quickly in child care centers. During flu season, watch for symptoms of flu and call the health department as soon as you notice any increase in flu associated with your program.

## **Giardiasis**

### **What is it?**

Giardiasis is a chronic diarrhea illness caused by a parasite (*Giardia lamblia*). It is diagnosed by examining the stool for the parasites.

### **What are the signs or symptoms?**

Some infected people have no symptoms. These people are called carriers. People who feel sick may experience some or all of the following:

- Foul-smelling greasy diarrhea
- Gas and bloating
- Abdominal cramping
- Nausea and vomiting
- Weight loss and weakness.

Bloody stools are not usually seen with *Giardia* infections. Animals such as beavers, cats, dogs, and cattle are infected the same way as humans.

### **How long does it take from exposure to development of Giardiasis?**

After exposure, it usually takes one to two weeks to develop the illness.

### **When is it contagious?**

As long as the organism is present in the stool. In most cases the germs will be completely gone in four to six weeks.

### **How is it spread?**

- *Giardia* is spread from person to person when a person touches the stool or an object which has been contaminated by the stool of an infected person, and then ingests the germs.
- Infection is often spread by not properly washing hands after bowel movements, after changing diapers or before preparing foods.
- *Giardia* may also be transmitted through contaminated water, such as in water play tables.
- Outbreaks have also been linked to portable wading pools and contaminated water supplies.
- Drinking water from lakes, streams, or ponds that are contaminated by infected animals and humans can cause infection.

### **When should people with Giardiasis be excluded?**

Exclude if there is diarrhea with illness, fever, or vomiting. After diarrhea resolves the person may return to child care.

### **How is it treated?**

Most health care providers agree that persons with *Giardia* who are ill and/or have diarrhea should be treated with medication.

**What can be done to prevent the spread of Giardiasis?**

- Exclude any child or adult with acute diarrhea.
- Make sure that all children and adults practice good hand washing techniques.
- In a large child care facility, the person preparing food should not change diapers.
- In a small child care facility, the child care provider should carefully wash hands after changing diapers and before handling foods.
- If possible, keep diapered children apart from toilet trained children.
- Wash and disinfect toys that can be put in a child's mouth after each child's use.
- Use diapers that can contain liquid stool or urine.
- Make sure that diapers have waterproof outer covers or use plastic pants.
- Children should wear clothes over diapers.
- Wash children's hands before they use water play tables.

**Who should be notified?**

Notify the local health department. They will provide you with further information.

## ***Haemophilus Influenzae* Type b (HIB)**

### **What is it?**

Hib is a type of bacteria that can cause infections of the ears, eyes, sinuses, epiglottis (the flap that covers the windpipe), skin, lungs, blood, joints, and coverings of the brain, and is a major cause of meningitis and permanent brain damage. These are very serious, *sometimes fatal*, illnesses in susceptible children. Children in group settings are at higher risk of catching this illness.

### **What are the signs or symptoms?**

Depending on the site of the infection, *early symptoms* may include:

- Sore throat
- Earache
- Fever
- Coughing
- Difficulty breathing
- Joint pain
- Skin lesions
- Headache

### ***Symptoms that may appear suddenly:***

- High fever
- Irritability
- Intense headache
- Nausea or vomiting
- Stiff neck

### **How long does it take from exposure to development of the disease?**

Two to four days.

### **When is it contagious?**

A person with Hib is contagious from the week previous to onset of symptoms until within 24 to 48 hours after starting effective antibiotic treatment.

### **How is it spread?**

Hib can be spread from one person to another by coughing or sneezing, or by contact with mucus or fluids from the nose and throat of a person with Hib.

### **What should be done?**

- Exclude children and staff that are ill with the disease until the local health department recommends they return.
- Exclude all children and staff exposed until preventive treatment has been given, if indicated and prescribed by a health care provider.
- **Hib infection is a vaccine-preventable disease.** Children should receive the vaccine according to the most recent immunization recommendations.

**When can the child or staff member be re-admitted?**

The child or staff member may return after being cleared by a health care provider.

**What can be done to prevent the spread of Hib?**

- To prevent disease make sure the children in your care (beginning from two months up to five years of age) are vaccinated.
- It is important to carefully observe those who are exposed, but who have not been vaccinated or completely immunized. Exposed children who develop an illness with fever need to be examined by a health care provider.
- All contacts should receive prophylaxis (preventive treatment), including those who have received the Hib vaccine.
- Make sure all children and staff use good hand washing practices.
- Keep the environment clean.
- Do not allow sharing of mouthed toys, bottles, cups or pacifiers.
- Clean and disinfect toys and hard surfaces frequently. Mouthed toys should be cleaned and sanitized after each use, or removed until cleaning takes place.

**Who should be notified?**

Notify the local health department. They will provide you with further information.

## **Hand, Foot, and Mouth Disease**

### **What is it?**

Hand, foot, and mouth disease (HFMD) is a viral infection caused by Coxsackie virus.

### **What are the signs or symptoms?**

- Tiny blisters in the mouth and on the fingers, palms of hands, buttocks, and soles of feet that last a little longer than a week.
- Poor appetite – blisters in the mouth and throat make it difficult to eat or drink.
- May see common cold signs or symptoms with fever, sore throat, runny nose, and cough.
- Vomiting and diarrhea can occur but are less frequent.

### **How long does it take from exposure to development of disease?**

Three to six days

### **When is it contagious?**

The virus may be shed for weeks to months in the stool after the infection starts; respiratory shedding of the virus is usually limited to one to three weeks.

### **How is it spread?**

- Respiratory route: contact with large droplets that form when a child talks, coughs, or sneezes.
- Direct contact with respiratory secretions from objects contaminated by children who carry the virus.
- Fecal-oral route: contact with feces of children who are infected.

### **What should be done? Should children with this illness be excluded?**

- Children with HFMD usually don't need treatment and will get better on their own within a week.
- There is no reason to exclude children with HFMD if they feel well enough to attend and do not require more care and attention than the program can provide.

### **What should be done to prevent the spread of HFMD?**

- Follow strict hand washing and personal hygiene procedures.
- Always wash hands, especially after using the bathroom, diapering or assisting children in the bathroom, and before eating or handling food.
- Wash and disinfect all articles contaminated with stool or mucus.

### **Who should be notified if an outbreak of HFMD occurs in the child care setting?**

- Notify parents and staff members.
- Make sure all children and adults use good hand washing technique.



## Head Lice (Pediculosis)

### What are head lice?

- Lice are parasites that live on the surface of the human body. An infestation of lice is called “pediculosis”.
- Head lice are wingless, crawling insects which live on the human scalp. They cannot reproduce without the warmth of the human head, nor can they survive without the blood provided by the scalp.
- Head lice are not a sign of poor hygiene, and *they do not carry disease*.
- Head lice should not be confused with body lice or crab lice.
- Head lice are found only on humans – not on dogs, cats, or other pets.

### What are the signs or symptoms?

- Excessive scratching of the head
- A tickling feeling or sensation of something in the hair
- Irritability and sleeplessness
- Sores on the head caused by scratching

### How long does it take from exposure to infestation?

One to two weeks.

### When are they contagious?

As long as there are live lice and eggs.

### How to look for head lice:

- Lice eggs, called *nits*, are found by close examination of the hair. Nits look like white or dark ovals, and are most noticeable on the back of the neck and around the ears at the base of the hair shaft.
- Nits attached firmly within ¼ inch of the base of the hair shaft suggests a person could be infected.
- Actual lice may be seen crawling on the scalp. Lice are about the size of a sesame seed. They can crawl, but they cannot jump or fly.
- In severe cases of infestation, head lice may also infest eyebrows and eyelashes.

### How are lice spread?

Head lice are spread through direct and indirect contact with infested objects or people:

- Head to head contact (very common in children as they play closely);
- Sharing combs, brushes, and hair accessories;
- Sharing hats and head coverings – such as in the “dramatic play” area;
- Storing children’s coats and jackets in a small area where they touch;
- Sharing bedding or providing a comfortable area with pillows where children might rest their heads.

**When should children be excluded from care and when can children be re-admitted?**

- When head lice are discovered on children it is not necessary to send them home immediately or exclude them from child care or school.
- Contact the parents of the child to inform them their child has head lice and let them know they will have to treat their child and the child's environment that evening.
- At the end of the day provide the parents with educational materials on proper treatment and nit removal.

**Treat the person**

- People with head lice and nits are treated with medication and manual removal.
- Read and follow the instructions on ALL products and treatments (over the counter OR prescription).
- It is important to remove as many lice and nits as possible. Careful combing of hair in small sections at a time with a fine tooth comb (one will come with the treatment) helps.

**Treat the environment**

- Machine wash on the hot cycle (130 degrees or hotter) all bed linens, clothing, and towels that have been in contact with the infested person within the last three days. Also wash the soft toys and stuffed animals that the child plays with and cuddles.
- Use a hot dryer setting for at least 20 minutes to dry clothes, linens, towels, soft toys, and stuffed animals after washing.
- Non-washable items can be vacuumed or dry-cleaned.
- If there are items which cannot be washed, vacuumed or dry-cleaned, these items can be "bagged" and sealed in plastic garbage bags for a period of two weeks. "Bagging" objects that can't be washed, dry-cleaned or vacuumed should be done with care and under parental supervision. Lice and nits cannot survive off the human body for this length of time without a blood meal.
- Vacuum carpet, upholstered furniture, mattresses, box springs, and car seats.
- All of the person's brushes, combs, and hair accessories (headbands, barrettes, and ponytail holders) must be treated as well.

The following methods are suggested:

Soak items in a mild bleach solution, rubbing alcohol, or Lysol for one hour, or  
Scrub items with soap and hot (130 degree) water. Rinse well.

**What can be done to prevent the spread of head lice?**

- Make head checks part of the daily health check. The earlier lice are found, the easier they are to treat and keep from spreading further.
- Head lice are treated with medication and manual removal. Thorough combing with a nit comb is important.
- Provide space for children's coats, sweaters, hats, and other personal belongings to be stored separately.
- Teach children the importance of not share clothing, hats, hairbrushes, or combs with other children.

### Treatment precautions

- ***Only use licensed and approved products for treatment of head lice.*** Home remedies such as mayonnaise, Vaseline, and tea tree oil are not consistently proven to be effective for the treatment of head lice. Tea tree oils can be irritating to the skin and are toxic to the liver in high doses.
- The treatment times of over-the-counter lice shampoos and rinses must not be extended beyond the package insert recommendations.
- The over-the-counter and prescription shampoos and rinses should not be applied too frequently.
- ***Gasoline, kerosene, or any other petroleum-based products*** which could be flammable **must not be used** for head lice treatment or nit removal.
- ***Products containing insecticides*** that are not labeled for use on humans **must not be used** for head lice treatment or nit removal.



## Headaches

### What is a headache?

Headaches are thought to be caused by changes in chemicals, nerves, or blood vessels in the area. These changes send pain messages to the brain and bring on an aching in the head.

### Headache triggers

In general, children get the same types of headaches as adults. Headaches can also be hereditary, so if a parent gets them, their children might too.

***Some of the potential headache triggers include:***

- Too little sleep or sudden changes in sleep patterns
- Extreme hunger or thirst
- Certain medications
- Being under a lot of stress
- Having a minor head injury
- Using the computer or watching TV for a long time
- Eye strain, including sun glare
- Smelling strong odors
- Taking a long trip in a car or bus
- Listening to really loud music
- Clenching or grinding teeth
- Tooth infections or abscesses
- Noisy, hot, stuffy environments
- Consuming certain foods or food additives (chocolate, caffeine, cheese, nuts, fried foods, aspartame, MSG)
- Changes in the weather
- Hormonal changes during a girl's menstrual cycle
- Physical exertion

***In some cases, headaches are caused by certain infections, such as:***

- Ear infections
- Viral infections, like the flu or common cold
- Strep throat
- Sinus infections
- Lyme disease

**Two common types of headaches are tension headaches and migraines.**

Fairly common in kids, ***tension-type headaches can cause:***

- A pressing tightness in the muscles of the head, radiating down the neck.
- Constant dull ache on both sides of the forehead.
- Pain that doesn't get worse with physical activity.
- A headache that's not accompanied by nausea or vomiting.

Tension headaches are characterized by a contraction of the muscles at the back of the head. Young children may withdraw from regular play and want to sleep more. Tension-type headaches can last from 30 minutes to several hours.

***Migraines can cause:***

- Throbbing, stabbing, or pounding pain on one or both sides of the front part of the head.
- Pain that worsens with exertion.
- Nausea.
- Vomiting.
- Abdominal pain.
- Dizziness.
- Extreme sensitivity to light, noise, and smells.
- Seeing spots or halos.

Migraine pain is caused by chemicals produced in the brain that alter blood vessels in the brain. The head pain typically lasts for several hours or even overnight. Some people with migraines get **auras**, a warning that a migraine is on the way. Common auras include blurred vision, seeing spots, flashing lights or smelling a certain odor.

**What should be done?**

Inform the child's parents of any headache symptoms. Keep written notes of other symptoms that accompany the headaches, as well as what the child was doing at the onset and anything he or she ate or drank.

**Suggest that the parents call the child's health care provider if the child's headaches:**

- Occur once a month or more.
- Don't go away easily.
- Are particularly painful.

**Notify parents to pick up child and contact the child's health care provider if the child has any of these symptoms in addition to the headache:**

- Decreased level of alertness
- Vomiting
- Headache when the child wakes up, or one that is so painful it wakes the child up
- Headache following a head injury or loss of consciousness
- Headache with seizure
- Visual changes
- Tingling sensations
- Weakness
- Clumsiness or difficulty walking or standing
- Difficulty speaking
- Neck pain or stiffness
- Unable to participate in everyday activities
- Fever or other signs of infection
- Change in personality
- Very thirsty – drinking a lot and/or urinating a lot

**Should a child with a headache be sent home?**

There is no reason to exclude the child if he or she feels well enough to attend and does not require more care and attention than the program can provide. If the headache becomes so severe that the child does not feel well enough to participate in activities, it would be best to contact the parents.

**How headaches are diagnosed**

- A physical examination is done, as well as taking a thorough medical history.
- More involved and invasive procedures such as CT scan, MRI scan, lumbar puncture, would be performed only if a serious condition was suspected.

**Treatment for headaches**

Treatment for a child's headaches will depend on what the doctor determines is the likely cause. Most everyday headaches can be cared for at home with little medical intervention.

***To help ease a child's pain, have him or her:***

- Lie down in a cool, dark, quiet room.
- Put a cool, moist cloth across the forehead or eyes.
- Relax.
- Breathe easily and deeply.

Make sure the child has had something to eat and drink.

Children with migraines may just want to sleep and may feel better when they wake up. A big part of treating migraines is avoiding the triggers that may have caused them. The child's health care provider may have asked the parent to keep a diary of all food and drink taken in that day, as well as what activities the child was participating in.

The parents of a child with headaches may want you to give the child an over-the-counter pain reliever such as acetaminophen or ibuprofen. Make sure they have filled out and signed the Medication Administration form.



## **Hepatitis A**

### **What is it?**

Hepatitis A is an infection of the liver caused by the Hepatitis A virus.

### **What are the signs or symptoms?**

Symptoms may include:

- Mild fever
- Loss of appetite
- Fatigue
- Nausea and vomiting
- Stomach pain
- Dark urine
- Discoloration of eyes and skin (jaundice)

Young children often have no symptoms or very mild symptoms. Adults and older children are more likely to have typical symptoms of the disease.

### **How long does it take from exposure to development of infection?**

It can take from two to six weeks.

### **When is it contagious?**

It is contagious from two weeks before symptoms appear to one week or more after onset of yellow discoloration. Some people spread the disease without being noticeably sick. Most children under three years of age have no symptoms when they have Hepatitis A.

### **Who gets it and how?**

- Anyone who has not had a Hepatitis A immunization can get this infection, which spreads quickly in groups of children who are not yet toilet-trained and who cannot wash their own hands well.
- Hepatitis A is spread through the fecal-oral route. This means the disease is spread by putting something in the mouth that has been contaminated with the stool of an infected person. It can also be spread when a person eats food or drinks beverages which have been handled by a person infected with Hepatitis A.
- Poor hygiene practices among staff with diaper-changing responsibilities and also those who prepare food can contribute to the spread of Hepatitis A.

### **What should be done?**

There is no treatment that cures Hepatitis A. However, because the incubation period is so long, in cases of possible outbreaks – the illness can be prevented by giving persons in the program and households a protective shot of immune globulin within two weeks of their exposure to the virus.

**When should people be excluded and when can they return?**

If a child or adult in your child care program is diagnosed with Hepatitis A:

- Exclude the person from child care until one week after the onset of symptoms.
- Immediately notify your local health department and they will provide you with further information.

**What can be done to prevent the spread of Hepatitis A?**

- Strictly enforce hand washing and universal precautions.
- Make sure all parents and child care personnel notify the program if any person in their household is diagnosed with Hepatitis A.
- *A vaccine is available to prevent Hepatitis A*, and is recommended for child care providers and for all children at age one year. There are two doses and they should be given at least six months apart.
- When outbreaks occur in child care settings, gamma globulin may be administered to unimmunized children, providers, and families of child care attendees to limit the transmission of Hepatitis A.

**Who should be notified?**

Notify the local health department. They will provide you with further information.

## Hepatitis B

### What is it?

Hepatitis B is a viral infection of the liver caused by the Hepatitis B virus. The virus is found primarily in the blood of an infected person and occasionally in other body fluids. It is more common in adults than in children.

### What are the signs or symptoms?

Symptoms include:

- Abdominal discomfort
- Loss of appetite
- Nausea
- Fever
- Tiredness
- Joint pain
- Dark urine
- Yellow skin or eyes (jaundice)

Only about 10% of children who become infected with Hepatitis B virus show any symptoms.

### How long does it take from exposure to development of the disease?

Usually 45 to 180 days, average 60-90 days.

### When is it contagious?

- A person can spread the virus as long as it remains in their blood.
- Hepatitis B is usually contagious from about one month before until one month after the start of jaundice.
- Some people carry and transmit the virus for life.

### How is it spread?

Hepatitis B is most often spread from person to person through contact with infected blood, semen, or vaginal secretions. Spreading can occur when infected blood or saliva enters through a cut or scraped area on the skin, or mucous membranes (like the lining of the mouth). Infected mothers can transmit it to a newborn during birth.

### When should people with this illness be excluded?

- A staff person with this illness should stay home until she or he feels well, and fever and jaundice are gone.
- A child or staff person with chronic hepatitis B infection who has open sores that cannot be covered should not attend child care until the sores are healed. Hepatitis B is usually contagious from about one month before until one month after the start of jaundice.
- You do not have to exclude a child who is a carrier of the Hepatitis B virus as long as she or he does not have uncontrolled biting or oozing skin lesions that cannot be covered.

**What can be done to prevent the spread of Hepatitis B?**

- ***Hepatitis B is vaccine-preventable.*** All infants should be vaccinated with three doses of Hepatitis B vaccine during the first 18 months of life. Children not previously vaccinated should receive three doses of vaccine by the age of 11 or 12 years. Child care providers should discuss with their doctor whether it is appropriate for them to receive hepatitis B vaccine.

***To reduce the spread of hepatitis B:***

- Assure that all children in your program are immunized. Verify if staff members have been immunized.
- Follow universal precautions and make sure all children and adults use proper hand washing practices.
- Protect staff and children by following special procedures for cleaning and handling of all body fluids.
- Wear disposable gloves to create a barrier when caring for open sores, wounds, cleaning up vomit that may have blood in it, and when changing a soiled diaper with bloody stools. Wash hands well after properly disposing of your gloves.
- Clean up all blood spills and diaper changing surfaces with soap and water, then disinfect with an EPA registered disinfectant, such as a bleach solution.
- Place disposable items contaminated blood or body fluids in sealed plastic bags in covered containers.
- Store clothing or other personal items stained with blood or discharges separately in a sealed plastic bag to be sent home with the child for appropriate cleaning. Ask parents to wash and then bleach these items.
- Do not allow sharing of personal items which may become contaminated with blood or bodily fluids such as toothbrushes, food, or any object that may be mouthed; and discourage aggressive behavior (biting, scratching) at the facility.

**Who should be notified?**

Notify the local health department. They will provide you with further information.

## Hepatitis C

### What is it?

Hepatitis C is a viral infection of the liver caused by the Hepatitis C virus (HCV).

### What are the signs or symptoms?

Children usually don't show any signs or symptoms. Adults often suffer from:

- Tiredness
- Loss of appetite
- Nausea
- Abdominal pain
- Fever
- Yellow skin or eyes (jaundice)
- Dark brown urine or pale-colored stools

### Who gets it and how?

- The viruses that cause Hepatitis C are spread through blood (exposure to blood and blood products from HCV infected persons) or other body fluids.
- It is also spread by infected mothers to newborn infants through blood exposure at birth.

### When should people with this illness be excluded?

- You do not have to exclude a child who is a carrier of the Hepatitis C virus as long as he or she does not have uncontrolled biting or oozing skin lesions that cannot be covered.
- A staff person with this illness should stay home until he or she feels well, and fever and jaundice are gone.

### What can be done to prevent the spread of Hepatitis C?

- Follow universal precautions and make sure all children and adults use proper hand washing practices.
- Protect staff and children by following special procedures for cleaning and handling of all body fluids.
- Wear disposable gloves to create a barrier when caring for open sores, wounds, cleaning up vomit that may have blood in it, and when changing a soiled diaper with bloody stools. Wash hands well after properly disposing of your gloves.
- Clean up all blood spills and diaper changing surfaces with soap and water, then disinfect with an EPA registered disinfectant, such as a bleach solution.
- Place disposable items contaminated blood or body fluids in sealed plastic bags in covered containers.

- Store clothing or other personal items stained with blood or discharges separately in a sealed plastic bag to be sent home with the child for appropriate cleaning. Ask parents to wash and then bleach these items.
- Do not allow sharing of personal items which may become contaminated with blood or bodily fluids such as toothbrushes, food, or any object that may be mouthed; and discourage aggressive behavior (biting, scratching) at the facility.

**Who should be notified?**

Notify the local health department. They will provide you with further information.

## Herpes Simplex

### What is it?

Herpes Simplex is a virus that can cause a variety of infections in different age groups. In early childhood, herpes simplex most commonly causes blister-like sores in the mouth and around the lips, and on skin that is in contact with the mouth, such as a finger or thumb that is sucked.

### What are the signs or symptoms?

- Fever
- Irritability
- Runny nose
- Tender swollen lymph nodes
- Painful, small fluid-filled blisters in the mouth, on the gums and lips
- Blisters may weep clear fluid and bleed and are slow to crust over
- Often there are no signs or symptoms

### How long does it take from exposure to development of infection?

It can take from two days to two weeks.

### When is it contagious?

#### *During the first infection:*

- People shed the virus for at least a week.
- Some continue to shed the virus for several weeks after symptoms appear.

#### *After the first infection:*

- The virus may be reactivated from time to time producing cold sores.
- People with cold sores shed the largest amount of virus for 3 to 4 days after symptoms appear.
- Virus shedding occurs at lowest levels in infected people who have no symptoms.

### How is it spread?

- Direct contact through kissing and contact with open sores.
- Contact with saliva (when children share mouthed toys).

### What should be done?

- Notify parents to watch for symptoms.
- Take extra precautions to control transmission of infected secretions.

### Should people with this illness be excluded?

- Only exclude a child with open blisters or mouth sores if the child is a biter, drools uncontrollably, or mouths toys that other children may put in their mouths.
- Exclude staff with open, oozing sores that cannot be covered.
- **Do not exclude** children or staff with skin blisters that can be covered.
- Children and staff that are excluded may return when blisters are crusted over.

**What can be done to prevent the spread of Herpes Simplex?**

- Make sure all children and adults use good hand washing practices.
- Wash and sanitize mouthed toys, bottle nipples, and utensils that have come in contact with saliva or have been touched by children who are drooling.
- Do not allow children to share toys that can be put in their mouths, as the virus may be present even when sores and symptoms are not noticeable.
- Do not kiss the child or allow the child to kiss others where direct contact with the sore may occur.
- Use gloves if applying medicated ointment to the sores.

**Who should be notified?**

Notify families whose children may have been exposed to watch for symptoms.

## Human Papillomavirus (HPV)

### What is it?

HPV is a common family of viruses that causes infection of the skin or mucous membranes and is spread through sexual contact. There are over 100 different types of HPV viruses and different types affect different areas of the body.

### What are the signs or symptoms?

- Warts or bumps in the genital area. They can be flat or raised, small or large, smooth or bumpy like cauliflower.
- Warts in the throat or mouth.
- Abnormal cells on the cervix, vulva, penis, mouth and throat, sometimes leading to cancer.

*HPV is the cause of almost all cervical cancers in women and has been linked to the rise of oral health cancers in young people.*

### How is it spread?

The virus is spread by direct sexual contact, even when there are no signs of warts.

### How long does it take from exposure until the disease develops?

It can take anywhere from a few months to over a year to develop signs of HPV after having contact.

### When is it contagious?

HPV can be spread when someone is carrying the virus, whether warts are present or not. It also can be spread even after warts have been treated and are no longer seen.

### What should be done?

- Inform parents about the HPV vaccine and recommend it for their boys and girls 11 – 12 years old.
- Inform and educate staff members about HPV and urge staff members to get the vaccine if they are under the age limit (men through age 21, women through age 26).
- A health care provider can diagnose and treat HPV.

### How is it treated?

There is no treatment for the virus itself, but the warts may be treated with prescribed creams or ointments that are applied in the health care provider's office or at home. Other treatments include removal of the warts with a laser or surgery.

### What can be done to prevent the spread of HPV?

- *The HPV vaccine is recommended for all boys and girls ages 11 or 12.*
- HPV vaccines are given in three shots over six months. It is important to get all three doses.
- Catch-up vaccines can be given for males through age 21 and females through age 26.
- For more information about who should receive the vaccine, see [www.immunize.org](http://www.immunize.org).

- It is always important to avoid direct unprotected contact with warts. People can spread HPV even when they don't have warts, so it is recommended that sexually active people use latex condoms correctly every time they have sex.
- Women between 21 and 65 years of age should be routinely screened for cervical cancer.

## Measles

### What is it?

Measles is a highly contagious and acute viral disease caused by the measles virus.

### What are the signs or symptoms?

- Fever, cough, runny nose, and red, watery eyes.
- Small red spots in the mouth.
- Appearance of a rash at the hairline spreading downward over the body.
- May have diarrhea or ear infection.
- Complications may be serious and result in pneumonia, brain inflammation, convulsions, deafness, permanent disability or death.
- Measles can cause miscarriage or premature delivery in pregnant women who have never had the disease and become infected.

### How long does it take from exposure to development of the disease?

*Incubation period:* 8 to 12 days from exposure to onset of signs and symptoms.

### When is it contagious?

It is contagious from one to two days before the first symptoms appear (four days before the rash) until four days after the appearance of the rash.

### How is it spread?

- **Respiratory route:** contact with large droplets that form when a child talks, coughs, or sneezes. These droplets can land on or be rubbed into the eyes, nose, or mouth.
- **Airborne route:** breathing small particles containing virus floating in the air. These particles travel along air currents and can infect children in another room.

### What should be done?

- Isolate the child.
- Notify the child's parent to pick up the child, and ask them to contact the child's health care provider.

### When can the child be re-admitted?

A person with measles should stay home until four days after the rash appears and until feeling well enough to participate in regular daily activities again.

### What can be done to prevent the spread of measles?

- **Measles is vaccine preventable.** Measles vaccine is usually administered as part of the MMR vaccine (measles, mumps, and rubella). Immunization of all children at 12 – 15 months, with a booster at ages four to six years, is required by state immunization laws for school and child care.
- Staff who have never had measles or been immunized for it should consult their health care provider.
- Adults born after 1957 may need a measles booster.

- Keep the ill child away from the child care program and away from pregnant women, infants and people with immune problems.
- Make sure all children and staff use good hand washing practices.
- Keep the environment clean.
- Clean and disinfect toys and hard surfaces frequently.
- Review immunization records to ensure that children are up to date with recommended immunizations.

**Who should be notified?**

Notify the local health department. They will provide you with further information.

## Meningitis

### What is it?

Meningitis means swelling of the spinal cord and the covering of the brain. Meningitis is usually caused by a virus or bacteria, but can also be caused by a fungus or parasite.

### What are the signs or symptoms?

#### *Symptoms can include:*

- Fever
- Rash
- Headache
- Stiff neck
- Nausea and vomiting
- Fatigue

Infants may be irritable, very drowsy, very fussy, or refuse to eat.

### How long does it take from exposure to development of the disease?

- Viral meningitis can start about three to seven days after being exposed.
- Bacterial meningitis can vary, but usually from one to ten days.

### When is it contagious?

- Viruses can be spread to others from about three days after someone is infected until about 10 days after they become sick.
- Bacteria can be spread to others from about 7 days before symptoms start until the ill person has been on antibiotics for at least 24 hours.

### How is it spread? Different forms of meningitis are spread in different ways.

- Viral meningitis is more common, and is spread through direct or indirect contact with feces of an ill person, usually by unclean hands.
- Bacterial meningitis is spread through direct or indirect contact with fluids from the nose or mouth of an ill person, usually by having close contact that includes coughing, kissing, or sharing items such as drinking or eating utensils.

**What should be done?** When a child develops these symptoms, remove him or her from contact with others and call the parents so take the child home. If the symptoms persist, the child should be taken to see a health care provider.

### How is it treated?

- Viral meningitis is treated with rest and fluids; antibiotics will not help someone recover from viral meningitis.
- Bacterial meningitis must be treated with appropriate antibiotics, prescribed by a health care provider.

**When can the child be re-admitted?**

For viral meningitis, when the symptoms are gone, when the treatment is completed, and when the child is able to participate in daily activities.

**What can be done to prevent the spread of meningitis?**

- Focus on thorough hand hygiene at appropriate times for children and employees.
- Teach children and employees to “Cover Your Cough” using a tissue (followed immediately by hand hygiene) or by covering their coughs or sneezes with their sleeves.
- Clean surfaces and items such as toys every day, and when saliva or nose and throat fluids are on them. In settings such as child care centers, wash objects with soap and warm water, removing visible soil, dirt and contamination before using a bleach solution:
  - For hard surfaces such as diaper-changing areas and bathrooms, use the bleach solution recommended for *disinfecting* based on the *New Bleach Solution Guidelines* in the Appendix.
  - For other objects such as toys and eating utensils, use the bleach solution recommended for *sanitizing* based on the *New Bleach Solution Guidelines* in the Appendix.
- Assure that all children (and staff) are appropriately immunized, especially with *the Hib vaccine*.

**Who should be notified?** Most types of meningitis are not reportable to the health department. Two types of bacterial meningitis are reported to the health department by hospitals and laboratories. If you have a question about a child in care or an employee who was told they have meningitis, please feel free to call the OSDH Acute Disease Service Epi-on-call at 405-271-4060.

**Comments:**

There are only two types of bacterial meningitis (*Neisseria meningitidis* and *Haemophilus influenzae* type b) for which other exposed child care attendees and employees may be recommended to receive antibiotics. The health department will notify you if this happens. The routine **childhood vaccines** protect children from most common causes of meningitis such as *Haemophilus influenzae* type b (Hib) and *Streptococcus pneumoniae*. Meningococcal vaccines are also recommended for children and some adults. For more information on these vaccines, call your health care provider or the local health department.

## **Molluscum Contagiosum**

### **What is it?**

Molluscum contagiosum is a virus that causes small bumps on the surface of the skin.

### **What are the signs or symptoms?**

Molluscum appear as separate, round bumps or lesions that are:

- Usually yellow, pink or flesh-colored
- Smooth, firm and dome-shaped
- Flat or slightly indented at the top
- Sometimes itchy, but not painful

They can occur in clusters and are frequently seen on the face, neck, trunk, arms, and hands.

### **How is it spread?**

- Through direct contact with the affected area on another person.
- It is also spread by using items such as towels, which were used by someone else with Molluscum contagiosum.
- A person can also spread infection to themselves by touching the bumps, then scratching other parts of the body.

### **How long does it take from exposure until the disease develops?**

It can take between one week and six months before symptoms appear.

### **When is it contagious?**

Probably as long as the bumps are present.

### **How is it treated?**

These usually heal without treatment, but in some situations may be removed by medical freezing, drainage, lasers or medications.

### **When can the child be re-admitted?**

Excluding the child is not recommended.

### **What can be done to prevent the spread of molluscum contagiosum?**

- Avoid direct contact with the skin bumps.
- Do not share towels, washcloths or clothing.
- Explain, model, and direct frequent hand hygiene.
- Covering the lesions is usually not necessary unless a child is picking or scratching them.
- Applying ice packs to itchy areas can help reduce the urge to scratch.



## Mononucleosis

### What is it?

Mononucleosis is a mildly contagious viral infection caused by the Epstein-Barr virus (EBV). It is commonly known as *mono*.

### What are the signs or symptoms?

#### *Symptoms can include:*

- Fever
- Sore throat, sometimes white patches on throat
- Fatigue
- Loss of appetite
- Swollen lymph nodes
- Enlarged liver and spleen
- Occasional skin rash

### How long does it take from exposure to development of the disease?

It's estimated to be 30 to 50 days.

### When is it contagious?

Experts think people with mono are most contagious from the time they first get infected and then for the next 18 months. The EBV stays in the body for life. The virus can show up in a person's saliva from time to time, and there's a chance that person may be contagious during these times. Some people have the virus in their bodies and never have any symptoms, but it is still possible to pass it to others.

### How is it spread?

- Person-to-person contact
- Kissing on the mouth
- Sharing objects contaminated with saliva (toys, toothbrushes, cups, bottles)
- May be spread by blood transfusion

### Should children with this illness be excluded from group settings?

#### *No, unless*

- The child is unable to participate and staff members determine they cannot care for the child without compromising their ability to care for the health and safety of the other children in the group.
- The child meets other exclusion criteria, such as fever with behavior change.

General exclusion of those with mononucleosis is not practical.

**When can children be re-admitted to group settings?**

- When exclusion criteria are resolved, the child is able to participate, and staff members determine they can care for the child without compromising their ability to care for the other children in the group.
- School-age children should avoid contact sports if they have an enlarged spleen, until their health care provider clears them.

**What can be done to prevent the spread of mononucleosis?**

- Practice proper hand washing techniques.
- Teach children to use tissues, or cover mouth and nose when coughing or sneezing.
- Ensure that all children have their own toothbrushes, cups and eating utensils.
- Disinfect toys and surfaces in infant or toddler rooms daily and after use; especially chew toys.
- Avoid kissing children on the mouth.

## Mumps

### What is it?

Mumps is an infection caused by the mumps virus that can result in swelling with tenderness of the salivary glands (the cheek and jaw area).

### What are the signs or symptoms?

#### *Symptoms can include:*

- Swollen glands in front of and below the ear or under the jaw
- Fever
- Headache
- General aches and muscle pains
- Earache
- Adolescent boys may have painful swelling of the testicles
- Adolescent girls may have painful swelling of the ovaries

*Complications include* meningitis, deafness (usually permanent), glomerulonephritis (kidney), and inflammation of joints. Mumps infection during the first three months of pregnancy may be linked to miscarriage.

### How long does it take from exposure to development of the disease?

16 to 18 days

### When is it contagious?

From six days before symptoms to nine days after the swelling begins.

### How is it spread?

- Respiratory route: contact with droplets that form when a person talks, coughs, or sneezes. These droplets can land on or be rubbed into the eyes, nose or mouth.
- Contact with the respiratory secretions from objects contaminated by people who carry the mumps virus.

### What should be done?

- Isolate the child.
- Notify parents to pick up the child and consult with their health care provider.
- If symptoms occur in a staff member they must leave the facility and contact their health care provider. They cannot return until five days after the onset of swelling.
- During outbreaks exclude exposed children who have not been immunized until they become immunized, or until the health department determines it is safe for them to return.

### When can the child be re-admitted?

- Five days after onset of swelling
- When the child is feeling well enough to participate in regular daily activities.

**What can be done to prevent the spread of mumps?**

- Prevention of mumps is possible through an *injection of vaccine* between 12 and 15 months with a booster at four to six years.
- Ensure up-to-date immunizations of children, staff members, volunteers, and family members according to current recommendations.
- Make sure all children and adults use good hand washing practices.
- Wash and sanitize mouthed toys, bottle nipples, and utensils that have come in contact with saliva or have been touched by children who are drooling.

**Who should be notified?**

Notify the local health department. They will provide you with further information.

## Norovirus

### What is it?

Noroviruses are viruses that cause intestinal illnesses.

### What are the signs or symptoms?

- Diarrhea
- Vomiting
- Stomach cramps
- Sometimes people with norovirus have a headache, muscle aches, or feel very tired.

People with norovirus usually recover in less than three days.

### How long does it take from exposure until the disease develops?

Symptoms usually begin about 24 – 48 hours after exposure, but can happen as soon as 12 hours after exposure.

### When is it contagious?

- It is most likely to be spread while a person has symptoms, especially diarrhea and vomiting.
- After symptoms are gone, people can still spread the virus for at least three more days.
- Norovirus can also stay on unclean objects and surfaces and still infect people after days or weeks.

### How is it spread?

- Norovirus is in the stool (feces) of people who are ill. Norovirus is very easily spread from person to person, and outbreaks are fairly common in group settings.
- It is spread by unclean hands or surfaces.
- Poor hand washing after using the bathroom spreads norovirus.
- Norovirus can stay on unclean objects and surfaces and infect people after days or weeks.

### What should be done?

- When a child has vomiting (2 or more times in a 24 hour period) or diarrhea (3 or more loose stools in a 24 hour period), they should be separated from others until a parent or designated adult can pick them up.
- Employees with these symptoms should go home.
- If a child or employee has been in the child care center or school while vomiting or having diarrhea, clean and disinfect any surfaces or objects that may have been contaminated.
- **Cleaning up vomit or diarrhea may release the germs into the air**, and they can be inhaled.
- **Wear disposable gloves and face masks** if cleaning large amounts of vomit or diarrhea.
- Clean up vomit and diarrhea promptly and carefully so that the germs are not released into the air. A good way to do this is to **cover the area with paper towels to absorb the body fluids**. Next carefully finish cleaning the area before using disinfectant.

- Immediately remove clothing or other personal items which have vomit or diarrhea on them and seal in a plastic bag to be sent home with the child for appropriate cleaning.
- Ask parents to wash with an approved detergent in hot water  $\geq 160^{\circ}$  F for  $\geq 25$  minutes. Dry in a hot dryer if fabric allows.
- For sheets and other non-disposable items that belong to the facility, handle as little as possible, without shaking or spreading the germs. Wash with an approved detergent in hot water  $\geq 160^{\circ}$  F for  $\geq 25$  minutes. Dry in a hot dryer if fabric allows.
- If laundry is not done at your facility, immediately place dirty clothes or linens in a plastic bag, then seal or tie the bag.

### **How is it treated?**

People usually recover on their own, but need to drink plenty of fluids, and treat the symptoms with over-the-counter medicines. It is NOT recommended to take an antidiarrheal medicine, which will cause the body to retain the virus instead of flushing it out. Antibiotics will not help with norovirus illness because antibiotics do not work on viruses.

**When can the child be re-admitted?** Any child or employee with symptoms of norovirus infection should be sent home and must not return until they are no longer symptomatic for 72 hours without taking antidiarrheal medicine.

### **What can be done to prevent the spread of norovirus?**

- Cleaning hands often is important in stopping the spread of norovirus. Hands should be washed vigorously with soap and water for at least 20 seconds:
  - Before eating or feeding children.
  - Before food preparation.
  - Before serving food.
  - After changing diapers, assisting with toileting or using the toilet.
  - After cleaning up vomit or diarrhea.
  - After handling dirty clothes or linen.
- Adults should supervise children washing their hands after using the toilet and before eating.
- Each sink should be supplied with an adequate amount of soap and paper towels.
- Always clean a surface or object well before disinfecting. Leave the disinfecting solution on the cleaned surfaces or objects for 10-20 minutes, and then rinse with water. Use one of these options for disinfection:
  - A commercial disinfectant that says on the label that it kills noroviruses, or
  - A diluted bleach solution, mixed daily, using regular unscented household bleach.  
See *New Bleach Solution Guidelines* in the Appendix.
- Areas to focus cleaning and disinfection (besides play areas) are frequently touched places such as doorknobs, faucets, sinks, toilets, bathroom surfaces, phones, counters (especially where food is prepared), chairs, tables and light switches.

**Who should be notified?** If more than one child or staff member becomes ill with symptoms of norovirus in a short period of time, contact the Acute Disease Service at 405-271-4060, and ask to speak with the Epi-on call. They will assist you in making sure you are doing everything you can to stop the spread of norovirus in your facility.

## **Pinworms**

### **What are they?**

Pinworms are small, white, threadlike worms that live in the large intestine. The female worms (resembling short, white threads less than half an inch long) come out through the anus at night and lay their microscopic eggs around the opening.

### **What are the signs or symptoms?**

- Itchy bottom.
- The child may be irritable and experience restlessness while sleeping.
- Anal irritation due to scratching.
- Sometimes thread-like worms are visible in child's bowel movement, but more often they are seen on the skin at the anus.

### **How long does it take from exposure to development of the infestation?**

It can take one to two months or longer from the time of ingesting the pinworm egg until an adult worm migrates to the anal area.

### **When are they contagious?**

Pinworms are contagious as long as the female worms are discharging eggs to the skin around the anus.

### **How are they spread?**

- Fecal-oral route, which means the germs of one person's bowel movement wind up in another person's mouth, usually by way of unwashed hands.
- By sharing toys, bedding, clothing, toilet seats, or baths. The eggs are light and float in the air. Pinworm eggs remain infective for two to three weeks in indoor environments.

### **How are they treated?**

- Several oral prescription medications are available for treatment of pinworms.
- The health care provider will often treat the whole family if one person in the house is infected, and will repeat the treatment two weeks later.

### **When should people with pinworms be excluded?**

Children and adults should be excluded **ONLY** until treatment has begun (initial dose).

### **What can be done to limit the spread of pinworms?**

- Practice good hand-hygiene technique at all times.
- Keep the child's fingernails short.
- Treatment with oral medication once or repeated in two weeks may be necessary
- Each child's clothing should be stored separately in plastic bags and sent home for laundering.

**Who should be notified?**

- Notify the parents of the infected child.
- Notify other parents and staff to watch for signs and symptoms.

## **Pneumonia**

### **What is it?**

Pneumonia is an inflammation of the lungs, most often caused by a viral infection, less commonly by a bacterial infection. It is often secondary to an infection that starts in the nose and throat area and then spreads to the lungs.

### **What are the signs or symptoms?**

Some signs and symptoms of pneumonia are:

- Fast difficult breathing
- Cough
- Fever
- Muscle aches
- Loss of appetite
- Lethargy

### **How long does it take from exposure to development of pneumonia?**

Pneumonia is caused by a variety of types of germs, so the time it takes to develop will vary.

### **When is it contagious?**

The contagious period depends on the germ that is causing the pneumonia.

### **How is it spread?**

- Pneumonia does not spread, but the germ that is causing the pneumonia can spread.
- Most of the germs that cause pneumonia spread by direct or close contact with mouth and nose secretions and touching contaminated objects.

### **How do you control it?**

- Make sure all children and staff use good hand washing practices.
- Wipe noses with clean tissues, dispose of them properly and wash your hands.
- Don't share food, cups, bottles, or toothbrushes.
- Teach children to cough into their elbow and away from people.
- Sanitize surfaces that are touched by hands frequently, such as toys, tables, and doorknobs.

### **Should children with pneumonia be excluded?**

*No, unless*

- The child is unable to participate and staff members determine they cannot care for the child without compromising their ability to care for the health and safety of the other children in the group.
- The child meets other exclusion criteria, such as fever with behavior change, rapid or distressed breathing, or persistent severe cough.



## **Respiratory Syncytial Virus (RSV)**

### **What is it?**

Respiratory Syncytial Virus or RSV is a viral infection of the respiratory system. It is the most common cause of acute respiratory diseases (such as bronchiolitis and pneumonia) in infants and young children.

### **What are the signs or symptoms?**

- Runny nose, congestion, and cough for most children.
- Very young infants can also experience:
  - Irritability
  - Poor feeding
  - Lethargy
  - Cyanosis (turn blue with cough or brief periods of no breathing).
- Respiratory problems include:
  - Bronchiolitis (wheezing from narrowed airways in lungs)
  - Pneumonia
  - Wheezing and asthma attack in children who already have asthma.
- Children with weakened immune systems, prematurity, or heart or lung problems have greater difficulty when ill with this infection.

In the early stages of RSV, symptoms are similar to the common cold: runny nose, sore throat, and low-grade fever. In most cases, the illness will not pass this point and resolve on its own in a few days. If the virus spreads to the lungs, the child develops a cough, chest congestion, and an expiratory (breathing out) wheeze. If infection progresses, a more persistent cough and shortness of breath are possible.

### **How long does it take from exposure until the disease develops?**

Usually from four to six days, but may range from two to eight days.

### **When is it contagious?**

Usually three to eight days.

### **How is it spread?**

- RSV is highly contagious and spreads easily from person to person by direct contact with nose and mouth secretions.
- The virus can live on surfaces, toys, and hands and infected children shed the virus before symptoms appear.
- Droplets from a cough or sneeze may also spread the infection.

### **What should be done?**

- Isolate the child only if other symptoms such as fever are present.
- Stress careful hand washing and appropriate hygiene with staff and children.
- Notify parents to pick up child immediately if he or she is having difficulty breathing and encourage medical supervision.

**What can be done to prevent the spread of RSV?**

- Practice frequent hand washing, especially when wiping a child's runny nose.
- Teach children to wash their hands after blowing their nose or coughing.
- Practice proper disposal of tissues.
- Clean and disinfect toys and hard surfaces frequently. Mouthed toys should be cleaned and sanitized after each use, or removed until cleaning takes place.
- Do not allow sharing of mouthed toys, bottles, cups or pacifiers.
- When possible, limit the time that children with high-risk conditions spend in child-care centers during the RSV season. Children at high risk for severe RSV disease should talk with their healthcare provider to see if a preventive medication (palivizumab) should be used as a preventive measure during RSV season.
- Children with RSV should stay home when having a fever or cough.

**Who should be notified?**

Other parents may be notified so they can be alert to symptoms in their own children. Very young children, infants, or those who have a compromised health status may be at risk for developing severe infection and complications.

## Ringworm

### What is it?

Ringworm is a fungal infection that may affect the body, feet, or scalp.

### What are the signs or symptoms?

#### *Skin*

- Ringworm appears as a flat, growing, ring-shaped rash.
- The edges of the circle are usually reddish and may be raised, scaly and itchy.
- Another type of ringworm fungus can cause the skin to become lighter in flat patches, especially on the trunk and face.

#### *Scalp*

- Infection begins as a small bump and spreads outward, leaving scaly patches of temporary hair loss.
- Patchy areas of dandruff-like scaling with or without hair loss.
- Redness and scaling of scalp with broken hairs or patches of hair loss.

#### *Feet*

- The skin between the toes scales and cracks.
- Blisters may be seen.
- On the nails, a chronic infection can cause thickening, discoloration and fragility.

### How long does it take from exposure to development of ringworm?

It takes from 10 to 14 days.

### When is it contagious?

A person with ringworm of the skin is infectious as long as the fungus remains present in the skin lesion. The fungus is no longer present when the lesion starts to shrink.

### How is it spread?

- Ringworm is spread by direct contact with a person or animal infected with the fungus.
- It can also be spread indirectly through contact with articles (such as combs or clothing), or with surfaces which have been contaminated with the fungus.

### What should be done?

- Isolate the child.
- Call the child's parents.
- Recommend a visit to the child's health care provider.
- Practice good hygiene to keep ringworm from spreading.

### When can the child be re-admitted?

- After prescription treatment and release by a health care provider.
- Once treatment has begun, there is usually no need to exclude the child, although you may need to cover areas infected with light gauze dressing.

**Who should be notified?** Call the parents of the infected child.



## **Roseola**

### **What is it?**

Roseola is a viral infection causing fever or rash in infants and children that primarily occurs between six and twenty-four months.

### **What are the signs or symptoms?**

- High fever (greater than 103 F) that lasts for three to five days
- The high fever can cause febrile seizures
- Runny nose
- Eyelid swelling
- Irritability and tiredness
- When the fever breaks a red, raised rash appears over the neck, chest and body and typically lasts from one to three days
- Some children will have no symptoms at all

### **How long does it take from exposure until the disease develops?**

It can take nine to ten days.

### **When is it contagious?**

After infection, the virus is present in the saliva on and off for the rest of a person's life.

### **How is it spread?**

Through sneezing, coughing, direct contact, such as eating or drinking after an infected child or handling personal items of the child.

### **What should be done?**

- Isolate from other children until parents arrive.
- A child with fever and rash should be excluded from child care until seen by a health care provider.

### **When can the child be re-admitted?**

After the fever breaks, a child may return to care while the rash is still present, provided the child feels well and is able to participate in all activities.

### **What can be done to prevent Roseola?**

Make sure all children and staff use good hand washing practices; especially after wiping or blowing noses, after contact with any nose, throat or eye secretions, and before touching food.



## Rotavirus

### What is it?

- A virus that causes diarrhea and vomiting.
- Before the vaccine was released in 2007, it was the single most common cause of diarrhea in children younger than two years.
- The disease occurs more frequently in cooler months.
- Nearly all children have been infected by the time they reach three years of age.
- Children can get infected more than once because the virus has many types.

### What are the signs or symptoms?

- Non-bloody diarrhea
- Nausea
- Vomiting
- Stomach pain
- Dehydration in severe cases

### How long does it take from exposure until the disease develops?

Symptoms usually begin about 24 – 72 hours after exposure.

### When is it contagious?

It is most likely to be spread while a person has symptoms, especially diarrhea and vomiting. After symptoms are gone, people can still spread the virus for at least three more days.

### How is it spread?

- Fecal-oral route: the virus is spread in the stool (feces) of people who are ill.
- It is spread by unclean hands, objects such as toys or surfaces, food and water.
- Rotavirus can stay on uncleaned objects and surfaces and still infect people after several days.
- People can spread the virus both before and after they become sick with diarrhea. They can also pass rotavirus to family members and other people with whom they have close contact.

### What should be done?

Exclude from group settings if:

- Stool is not contained in the diaper for diapered children.
- Diarrhea is causing accidents for toilet trained children.
- Stool frequency exceeds two or more above normal for that child.
- Stool is all black, or there is blood or mucus in stool.
- The child meets other exclusion criteria, such as fever with behavior change.

Exclude any child or employee who has diarrhea along with illness, fever, or vomiting.

**How is it treated?**

- There is no treatment or cure. Antibiotic drugs will NOT help because antibiotics fight against bacteria not viruses.
- It is important to prevent dehydration by drinking plenty of fluids. If a child becomes severely dehydrated, he may need to receive intravenous (IV) fluids in a health care setting.

**When can the child be re-admitted?**

- Once diapered children have their stool contained by the diaper, and when toilet trained children do not have toileting accidents.
- When the child is well enough to participate in group activities.

**What can be done to prevent the spread of Rotavirus?**

- *Rotavirus is a vaccine preventable disease.* Follow the most recent immunization recommendations.
- Practice good hand washing.
- Clean and sanitize objects and surfaces regularly.
- Exclude children from care when symptoms require it.

## Roundworm Infection (Toxocariasis)

### What is it?

*Toxocariasis* is an infection transmitted from animals to humans caused by the parasitic roundworms commonly found in the intestine of dogs and cats.

### Who is at risk for *toxocariasis* or roundworm infection?

Anyone can become infected with *Toxocara*. However, some people are at higher risk of infection, including:

- Children
- People who accidentally eat dirt
- Dog or cat owners

### How serious is infection with *Toxocara*?

- In most cases, *Toxocara* infections are not serious, and many people, especially adults infected by a small number of larvae (immature worms), may not notice any symptoms.
- The most severe cases are rare, but are more likely to occur in young children, who often play in dirt, or eat dirt contaminated by dog or cat feces.

### What are the signs or symptoms?

- Many people do not have symptoms and do not ever get sick.
- Some people (usually children) get sick from the infection and may have:
  - Fever along with damage to organs in their body, problems breathing, or stomach pain.
  - Eye disease that causes vision problems, eye pain, or eye redness.

### How is the roundworm infection spread?

- Dogs and cats infected with *Toxocara* shed *Toxocara* eggs in their feces.
- People become infected by accidentally swallowing dirt that has been contaminated with dog or cat feces that contain *Toxocara* eggs.
- Although it is rare, people can become infected from eating undercooked meat containing *Toxocara* larvae.
- The disease is not spread by person-to-person contact.

### What should be done?

If you think a child may have roundworm infection, notify the parents and encourage them to take the child to their health care provider for an exam.

### What can be done to prevent Roundworms?

- Use good hand washing practices – especially after playing outside or with animals.
- Supervise children closely outdoors and teach not to eat dirt.
- Dispose of dog and cat feces promptly and wash your hands after handling pet waste.
- Cover sandboxes and restrict animal access to play areas.
- Take your pets to the veterinarian to prevent infection with *Toxocara*. Your veterinarian can recommend a testing and treatment plan for de-worming.



## **Rubella (German Measles)**

### **What is it?**

Rubella, also called German measles or three-day measles, is a childhood disease caused by the rubella virus.

### **What are the signs or symptoms?**

- Mild fever
- Swollen lymph glands behind the ears
- Red or pink rash appearing first on the face, then spreading down over the body
- Many experience joint aches or pain

### **How long does it take from exposure to development of the disease?**

Two to three weeks.

### **When is it contagious?**

- Seven days before rash appears.
- 14 days after rash appears.
- Children are most contagious three to four days before and until seven days after.

### **How is it spread?**

It is spread by saliva and respiratory discharges from the nose and mouth, through the air, or on hands and surfaces.

### **What should be done?**

- Isolate the child.
- Contact the parents to take the child home.

### **When can the child be re-admitted?**

- Seven days after the onset of the rash.
- When the child is able to participate in daily activities.

### **What can be done to prevent the spread of Rubella?**

- All *children should be fully immunized against rubella* following the recommended schedule.
- Make sure all children and staff use good hand washing practices.
- All female staff in the childbearing years should have a blood test for sensitivity to rubella.
- Keep all pregnant women, infants and unimmunized individuals away from a person ill with rubella.
- Follow universal precautions.
- Carefully observe other children, staff, or family members for symptoms.

### **Who should be notified?**

Notify the local health department, they will provide you with further information.



## Salmonella

### What is it?

It is an intestinal infection caused by *Salmonella* bacteria and is a common cause of diarrheal illness in the United States.

### What are the signs and symptoms?

- Diarrhea
- Fever
- Abdominal pain
- Nausea and vomiting
- Sometimes blood or mucus in stool

### How long does it take from exposure to development of disease?

It takes about 12 to 36 hours, though the earliest symptoms may start within six hours.

### When is it contagious?

A person is able to infect others once they start having diarrhea.

### How is it spread?

- Ingestion of contaminated food, water, meats, eggs, and unpasteurized milk.
- Fecal-oral route: contact with feces of infected children and animals.
- Animals such as birds, turtles and lizards often carry salmonella.

### Should the child be excluded from group setting?

*The child should be excluded from group care when:*

- The diarrhea is not contained in the diaper for diapered children.
- Diarrhea is causing “accidents” for toilet-trained children.
- Stool frequency exceeds two or more stools above normal for that child.
- There is blood or mucus in the stool.
- The stool is all black.
- Dry mouth, no tears, or no urine output in eight hours.
- Child is unable to participate in daily activities.

### When can the child be re-admitted?

The child should not return to care until 24 hours after diarrhea has stopped (without anti-diarrhea medication) and the child is able to participate in daily activities.

### What can be done to prevent the spread of Salmonella?

- Use good hand hygiene at all times. Make sure children and staff wash their hands after handling animals and cleaning cages or pens.
- No reptiles or amphibians (turtles, snakes, lizards, iguanas, frogs, toads, and newts), in child care facilities or schools.
- Limit the serving of snacks and treats prepared outside the facility and served for special occasions to those from commercial sources.

- Do not serve children raw or undercooked eggs.
- Poultry and meat should be stored in a refrigerator and well-cooked, not pink in the middle.
- Children should not eat or drink raw or unpasteurized fruit juice or dairy products.
- Use proper sanitation methods for food processing, preparation, and service.

**Who should be notified?**

- Notify all parents and staff there is a case of salmonella.
- Notify the local health department. They will provide you with further information.

## Scabies

### What is it?

Scabies is a skin infection caused by a tiny bug called a mite. The mite burrows into the skin, causing a rash.

### What are the signs or symptoms?

- Rash with severe itching (increased at night).
- Itchy red bumps or blisters found on fingers, toes, wrists, elbows, armpits, waistline, thighs, abdomen, genital area and lower buttocks.
- In infants and young toddlers the rash may look different and can also occur on the face or scalp.

### How long does it take after exposure before symptoms appear?

- Four to six weeks for those who have never been infected.
- One to four days for those who have been previously infected.

### When is it contagious?

It is contagious until the mites and eggs are destroyed by treatment. The mites can survive only three days off the body and cannot jump or fly.

### How is it spread?

Direct skin-to-skin contact and contact with contaminated clothing, towels, and bed linens is the usual way scabies is spread.

### What should be done?

- Isolate the child.
- Notify the parents and request they take their child to a health care provider for treatment.
- Check other children for unrecognized cases.
- Notify parents of children who may have had direct contact with the infected person.

### When can the child be re-admitted?

The child should not return to group care until diagnosed and treated for 24 hours. Household members should be checked and treated at the same time if necessary.

### What can be done to prevent the spread of scabies?

- Proper and frequent hand washing.
- Look for signs of scabies in the morning health check and refer suspected cases.
- Do not share hats and jackets.
- Keep personal clothes and bedding separate.
- Launder bedding and clothes used in the 48 hours prior to treatment. Wash in a machine and dry in a hot dryer.
- Store difficult to wash items (such as stuffed toys and pillows) in tightly closed plastic bags for four days before using again.
- Vacuum carpets, upholstered furniture, and car seats.



## **Shigella**

### **What is it?**

Shigella is a bacterial infection of the large intestine.

### **What are the signs or symptoms?**

- Loose, watery stools with blood or mucus
- Fever
- Headache
- Nausea and vomiting
- Abdominal pain
- Convulsions

### **How long does it take after exposure before symptoms appear?**

Illness generally begins one to four days after exposure.

### **When is it contagious?**

Although symptoms usually disappear without treatment after four to seven days, bacteria may still be passed through the stool for up to four weeks.

### **How is it spread?**

- It is spread through the fecal-oral route: contact with stool of children who are ill.
- It is spread when diarrheal stools get on hands or objects and then onto other children's hands and mouths.
- It can also be spread through stool-contaminated food, drink, or water.

### **What should be done?**

- Exclude child from group setting if stool is not contained in the diaper for diapered children, or diarrhea is causing "accidents" for toilet-trained children.
- When Shigella is identified, the child should not return to group care until completion of five days of antibiotics or two successive stool cultures are negative.

### **How is it treated?**

- Plenty of fluids to prevent dehydration.
- Prescription antibiotics may be used during outbreaks, for severe illnesses or to protect people at high risk of complications.

### **What can be done to prevent the spread of Shigella?**

- Practice proper hand washing techniques.
- Make sure procedures for cleaning and disinfecting toys are being followed, and that toys are cleaned and disinfected between uses by children who are likely to put them in their mouths.
- Eliminate access to shared water play areas during a known outbreak.

**Who should be notified?**

Notify your local health department if someone in your program has this disease. They will provide you with further information.

Prompt intervention may help prevent the spread of Shigella to others.

## Shingles (Herpes Zoster)

### What is it?

Shingles is a painful rash illness which appears as crops of small blisters. It is caused by the varicella zoster virus, the same virus that causes chickenpox. After a person has had chickenpox, the virus may reappear later as Shingles.

### What are the signs or symptoms?

- Before the rash develops, itching, tingling, and pain may occur.
- The rash begins with raised reddish bumps which become blisters.
- It usually appears on one side of the body.
- The blisters crust over and fall off after 7 to 10 days.
- Some people continue to have pain even after the rash is gone.

### How long does it take from exposure to development of the disease?

- The virus can remain inactive in the body for many years after the original chickenpox infection.
- Exposure to shingles can cause chickenpox in a person who has not had chickenpox or the varicella vaccine.

### When is it contagious?

The blisters of a person with shingles are contagious until they have dried and crusted.

### How is it spread?

- Shingles cannot be passed from one person to another.
- The virus that causes shingles can cause chickenpox in someone who has never had chickenpox through touching the rash.
- A person with shingles can spread the virus when the rash is in the blister-phase.

### What can be done to prevent the spread of the virus?

- Use good hand washing practices at all times.
- Avoid touching the rash area and cover the rash if participating or teaching in a group setting.
- There is now a *shingles vaccine* recommended for people 60 years of age and older.



## **Skin Infections including Staphylococcus (“Staph”), Impetigo and MRSA (Methicillin-resistant *Staphylococcus aureus*)**

### **What are they?**

Skin infections are usually caused by bacteria such as *Staphylococcus* (also known as “staph”). They are usually mild. Rarely the bacteria can cause more serious illness. Therefore it is very important for skin infections that are not improving to be examined by a health care provider.

### **What are the signs or symptoms?**

- Skin infections usually start as a “break” in the skin which becomes red and tender.
- The area may be swollen, and there may be pus present.
- A skin infection may also look like a rash.

### **How are they spread?**

Skin infections are spread from person to person by *direct contact* with someone’s skin infection. Touching objects or surfaces that have had drainage from someone’s skin infection can also spread infection. This is known as *indirect contact*.

### **What should be done?**

- Keep skin infections completely covered with a bandage such as Band-Aid®.
- If the bandage becomes soaked or loose, remove it and throw it away in a trash can, wash your hands, then place a clean bandage over the infection.
- If the infection cannot be covered by a bandage, or if the child or worker will not leave the bandage on, then they need to be excluded from the child care setting until the infection has healed or can be kept covered.

### **How is it treated?**

Most skin infections will heal by keeping the area clean and covered with a bandage. Antibiotics are rarely needed. If a skin infection does not improve, or if it spreads, ask the parent to take the child to see his health care provider.

### **When can the child be re-admitted?**

A child with a skin infection can attend child care if the infected area can be completely covered by a bandage, and if the child is cooperative in leaving the bandage in place.

### **What can be done to prevent skin infections?**

When you first notice a break in your skin, wash it with soap and running water, and then put a clean, dry bandage over it. Change the bandage if it becomes wet, dirty or loose. Keeping your skin clean and free from contamination will help to prevent skin infections.

### **What can be done to prevent spreading skin infections to others?**

*You can prevent spreading skin infections to others by following these steps:*

1. Keep any skin infections covered at all times with clean, dry bandages, especially if pus or drainage is present. Keep wound drainage from getting on others, or on objects or surfaces.

2. Wash your hands often, especially after touching the area of infected skin, and before touching anything else.
3. Advise your family and others to wash their hands more often, especially if they touched the affected area or any items that had contact with it.
4. Wear disposable latex or vinyl gloves if you are caring for a skin infection other than your own. Always remove and dispose of gloves immediately and wash your hands with soap and water.
5. Do not share personal items such as towels, washcloths, razors, clothing, or uniforms that may have had contact with pus or drainage.
6. Wash soiled bed linens and clothes with hot water (at least 160° F), laundry detergent and (when possible) bleach. Using the hottest setting on your clothes dryer (commercial dryers are hottest) instead of air-drying will help kill bacteria.
7. Put all bandages or items with any pus or drainage (including blood and nasal discharge) immediately into the trash.
8. Clean all possible contaminated surfaces with a commercial disinfectant or with the bleach water solution recommended for disinfecting based on the new *Bleach Solution Guidelines* in the Appendices. This solution must be mixed fresh daily to be effective.

## **Strep Throat and Scarlet Fever**

### **What are they?**

A variety of infections, including strep throat, scarlet fever and impetigo are caused by Group A Streptococci bacteria.

### **What are the signs or symptoms?**

#### ***Signs of strep throat:***

- Very red and painful throat
- Fever
- Tender and swollen lymph nodes in neck
- Headache
- Stomachache
- Decreased appetite

*Scarlet fever* is a type of streptococcal infection characterized by a skin rash.

- Fine red bumps that feel like sandpaper
- Rash appears on the neck, chest, armpit and groin area and may only last a few hours
- Flushed cheeks
- Paleness around the mouth
- A red tongue that resembles the surface of a strawberry

### **How long does it take from exposure before symptoms appear?**

Two to five days.

### **When is it contagious?**

Strep throat is probably contagious before symptoms appear and continues to be infectious until treated for 24 hours.

### **How is it spread?**

- The Group A Streptococci are transmitted from one person to another through direct contact with the respiratory discharges of infected persons.
- Contact with the respiratory secretions from or objects contaminated by people who carry strep bacteria.
- Close contact helps the spread of the infection.

### **What should be done?**

1. Isolate the child from the other children.
2. Contact the parents to pick up the child and consult with the child's health care provider.

### **When can the child be readmitted?**

If the health care provider diagnoses strep throat, the child may return 24 hours after antibiotics have been started.

**What can be done to prevent the spread of Strep?**

- Make sure all children and adults use careful hand washing practices.
- Teach children to cough and sneeze into their elbow, wipe noses with clean tissues, throw the tissue into the wastebasket, and wash hands.
- Do not allow food to be shared.
- Do not kiss children on the mouth.
- Open windows indoors and maximize outdoor play.
- Parents who become aware that their child has strep throat or scarlet fever should inform caregivers.

## Styes and Eyelid Conditions

### What is it?

A sty is a mild infection in the eyelid at the base of the eyelashes or near the edge of the eyelid.

### What are the signs or symptoms?

- A red bump on or near the edge of the eyelid that is similar to a pimple
- Eyelid pain
- Eyelid swelling
- Tearing

*Styes typically don't cause vision problems.*

### When is it contagious and how is it spread?

- Styes may drain pus that contains bacteria. This could be contagious to others, but the drainage period is usually brief.
- Styes are contagious, but everyone has the sty causing bacteria in their body. At any age we have the potential to develop a sty without outside contamination.

### What should be done?

- Never "pop" a sty.
- Most styes heal on their own within a few days.
- To encourage healing and provide comfort apply warm compresses to eye for 10 minutes three or four times a day.

### Other eyelid conditions:

- **Chalazia:** often mistaken for a sty, a chalazion (kah-LAY-zee-on) is an enlarged, blocked oil gland in the eyelid. A chalazion mimics a sty for the first few days, then turns into a painless hard, round bump later on.
  - Most chalazia develop farther from the eyelid edge than styes.  
The same treatment used for a sty speeds the healing of a chalazion, though the bump may linger for one to several months.
  - If the chalazion remains after several months, an eye doctor may drain it or inject a steroid to facilitate healing.
- **Milia:** also called "milk spots" or "oil seeds," milia are tiny white cysts, usually appearing on the outer skin layer (epidermis) of the eyelid and around the eyes and nose.
  - They occur when dead skin cells don't slough off normally and are trapped at the base of a sweat gland or hair follicle, forming a raised "pinhead" bump that looks similar to a whitehead.
  - Milia are most common in newborns, but adults also can be affected. In babies, milia tend to clear up on their own over a week or two, but most adults will require medical treatment.
  - The preferred method of removing a bothersome milial cyst is by a simple surgical excision (no stitch is needed) by your dermatologist.

- **Xanthelasma:** A subtype of xanthoma (zan-THOE-mah), this skin condition is characterized by yellowish bumps (plaques) under the skin, occurring on or around the eyelids.
  - Xanthelasma (zan-thah-LAZ-mah) generally appear as disc-like lesions with a flat surface and well-defined borders, ranging in size from several millimeters up to three inches in severe cases.
  - They are usually non-symptomatic, but can be surgically removed by your doctor for cosmetic purposes.
  - They are caused by a build-up of certain fats, namely cholesterol, under the surface of the skin and often are attributed to elevated lipid levels in the blood stream such as high cholesterol.
  - The growth is non-cancerous, but elevated blood lipids could increase your risk of cardiovascular disease and should be investigated further by your doctor.

See the *All About Vision* website for further information. <http://www.allaboutvision.com>

## **Thrush**

### **What is it?**

Thrush is a yeast-like fungus infection.

### **What are the signs or symptoms?**

- White lesions on inner cheeks and tongue, and sometimes on the roof of the mouth, gums and tonsils.
- Slightly raised lesions with a cottage cheese-like appearance.
- Redness or soreness that may be severe enough to cause difficulty eating or swallowing.
- Slight bleeding if the lesions are rubbed or scraped.
- Cracking and redness at the corners of the mouth.

### **Infants and breast feeding mothers**

- In addition the distinctive white mouth lesions, infants may have trouble feeding or be fussy and irritable.
- The infants can pass the infection to their mothers during breast feeding.
- The infection may then pass back and forth between the mother's breasts and the baby's mouth.

### **When is it contagious?**

As long as the white lesions are present.

### **How is it spread?**

- Person to person contact.
- Babies sharing the same bottles, cups, and eating utensils.
- From breastfeeding mothers to their babies and back to the mothers.

### **What should be done?**

- Notify the child's parent about possible thrush.
- Ask parent to seek medical attention for the child.

### **When can the child be re-admitted?**

The infected child does not need to be excluded.

### **What can be done to prevent the spread of Thrush?**

- Closely supervise the use of pacifiers and bottles.
- Use good hand washing practices at all times.
- Use disposable eating utensils for the infected child.
- Wash and sanitize all toys mouthed by children.



## **Tuberculosis (TB)**

### **What is it?**

Tuberculosis (TB) is an infectious disease caused by bacteria, which usually affects the lungs. However, other parts of the body can also be affected.

### **What are the signs or symptoms?**

General symptoms may include:

- Feeling weak or sick
- Weight loss
- Fever
- Night sweats
- Cough
- Chest pain

Most children initially infected with the bacteria do not have signs or symptoms.

- Two to ten weeks after initial infection, they will react to a tuberculin skin test.
- If an infected child does develop signs or symptoms of TB, it most often occurs one to six months after the initial infection and may include:
  - Chronic cough
  - Weight loss
  - Fever
  - Growth delay
  - Night sweats
  - Chills

### **How long does it take from exposure to development of the disease?**

The risk of disease after infection is highest in the first two years, but the bacteria can be carried in the body for many years before active disease develops.

### **When is it contagious?**

- Individuals with infection but without active disease are not contagious – they are referred to as latent TB infection.
- Adults and some adolescents who have active TB spread the bacteria by coughing and contaminating the environment.
- The disease will remain active in someone who has developed symptoms of TB until the person is treated.

### **How is it spread?**

- Airborne route: breathing small particles containing these bacteria in the air, as a result of someone with active TB coughing or sneezing.
- Infection of children is nearly always the result of close contact with an adult who has active TB.
- Generally, infants and children with active TB disease are not contagious because when they cough they do not create enough force to expel large numbers of TB germs into the air.

**What should be done and how do you prevent the spread of TB?**

- Make sure all children and adults use good hand washing practices.
- Teach children and staff to cough and sneeze into their elbow, wipe noses with clean tissues, throw the tissue into the wastebasket, and wash hands.
- Provide adequate ventilation.
- Tuberculin skin testing of children and staff may be necessary if there has been an exposure to TB.
- Exclude children and adults with active TB infection and ensure they receive prescribed medication from their health care provider.

**When can the child with active TB be re-admitted?**

- After prescribe medication has been started.
- When the child is approved to return by local health officials and is considered noninfectious to others.
- When the child is able to participate in daily activities.

**Who should be notified?**

Notify the state or local health department. They will provide you with further information.

## Urinary Tract Infection

### What is it?

A urinary tract infection is an infection of one or more parts of the urinary system – the kidneys, the tubes that join the kidneys to the bladder (ureters), the bladder, and the tube that leads from the bladder to the outside (the urethra).

### What are the signs or symptoms?

- Pain, burning, stinging sensation when urinating.
- Increased urge to urinate or frequent urination (though a very small amount of urine may actually be produced).
- Fever.
- Wetting problems in children that are toilet trained.
- Low back pain or abdominal pain in the area of the bladder (below the navel).
- Foul-smelling urine that may look cloudy or contain blood.

*Signs and symptoms in infants and toddlers* (children still in diapers) may be very general – they may seem irritable and have a poor appetite. Sometimes the only symptom is a fever that doesn't go away.

### When is it contagious?

Urinary tract infections are not contagious.

### How is it spread?

- Infection usually occurs from bacteria from feces on the skin that enter the urethra, particularly in girls.
- Urinary infection is more common in children with constipation and who do not fully empty their bladders when voiding.
- Less commonly, it is caused by bacteria from the bloodstream entering the kidneys.
- Urinary tract infection is not passed from one person to another.

### What should be done?

- Keep track of the child's trips to the bathroom and symptoms.
- Notify the parents if the symptoms are a concern and recommend they contact the child's health care provider.
- Urinary tract infections are treated with antibiotics.
- There is no reason to exclude a child with a urinary tract infection unless the child meets other exclusion criteria or is unable to participate in daily activities.

### What can be done to prevent the spread of urinary tract infections?

- For infants and toddlers – change diapers frequently and clean up correctly.
- Teach children good hygiene, and to wipe from front to back.
- Children should be taught not to “hold it in” when they have to go because urine that remains in the bladder gives bacteria a good place to grow.
- Encourage the child to drink plenty of fluids (water).
- Girls should avoid bubble baths and strong soaps that might cause irritation.



## **Vomiting**

### **What is it?**

Vomiting is the forcible emptying of the stomach contents through the mouth.

### **What are the signs or symptoms?**

- Children with vomiting from an infection often have diarrhea and sometimes fever.
- Prolonged or severe vomiting can result in children becoming dehydrated, which means their bodies lose nutrients and water, leading to further illnesses.

### **When is it contagious?**

If the vomiting is associated with an infection, the contagious period depends on the type of germ causing the infection.

### **How is it spread?**

Direct contact with vomit can result in the spread of certain infections.

### **What should be done?**

- Use good hand washing practices at all times.
- Clean and disinfect surfaces that have been contaminated with body fluids.
- Exclude children if:
  - Vomited more than two times in 24 hours.
  - There is vomiting and fever.
  - Vomit appears green or bloody.
  - There is no urine output in eight hours.
  - There is a history of a recent head injury.
  - The child looks or acts very ill.

### **When can the child be re-admitted?**

- When the vomiting has stopped for at least 24 hours.
- When the child is able to participate in daily activities.



## Warts

**What are warts?** Warts are skin growths caused by a virus called human papilloma virus. There are many different types of human papilloma viruses. Some cause warts on the hands, some on the feet and some in the genital areas.

### **What are the signs or symptoms?**

- Warts may appear as a single bump or a series of bumps on the skin.
- They may have a “cauliflower” appearance.
- Warts are generally painless unless they are irritated.

**Who is at risk for warts?** People of all ages can get warts.

**How long does it take from exposure until warts develops?** It can take weeks or months before a wart appears after the skin is infected.

**When is it contagious?** This is not known. It might be as long as a person has warts.

### **How are warts spread?**

- Warts are spread by direct contact with someone who has warts.
- Some warts, such as warts on the bottoms of the feet (called plantar warts), can be caused by contact with contaminated surfaces such as public shower floors.

**How is a person diagnosed?** It depends on the type of warts a person has. Refer the parent to their health care provider if needed.

**What is the treatment?** Warts may not always need to be treated, but if so, the treatments can vary. Warts can be removed by freezing, chemical or surgical means if needed.

### **Should children or others be excluded from day care, school, work or other activities if they have warts?**

Exclusion is not necessary since warts are not likely to cause serious health problems.

### **What can be done to prevent the spread of warts?**

Good and frequent hand washing, along with keeping surfaces and objects cleaned and disinfected are important to prevent the spread of warts.



## **Whooping Cough (Pertussis)**

### **What is it?**

Whooping cough is a serious respiratory infection caused by bacteria that is highly contagious. It gets its name from the whooping sound the child makes when trying to inhale after a coughing spell.

### **What are the signs or symptoms?**

- Begins with cold-like symptoms – runny nose and cough.
- Coughing may progress to severe coughing, which may cause
  - Vomiting
  - Loss of breath, difficulty catching breath
  - Cyanosis (blueness).
- Whooping sound when inhaling after a period of coughing.
- Coughing persists for weeks to months.
- Usually no fever or very minimal.
- Symptoms are more severe in infants younger than one year.
- Infants may develop complications that require hospitalization, such as:
  - Pneumonia
  - Ear infections
  - Swelling of the brain.

### **How long does it take from exposure to development of the disease?**

Five to 21 days.

### **When is it contagious?**

From the beginning of symptoms until two weeks after the cough begins, depending on age, immunization status, previous episodes of infection, and antibiotic treatment.

### **How is it spread?**

Respiratory route: it is spread through the air after an infected person coughs or sneezes, and other people breathe in infected droplets.

### **What should be done?**

- Isolate the child with symptoms from other children until parents arrive.
- Recommend parents take the child to the health care provider and ask them to let you know what they find out.
- Watch for symptoms in other children.
- Exclude infected persons from the program.

### **When can infected children and staff return to the program?**

- After five days of appropriate antibiotic treatment, or after three weeks from the beginning of the cough if antibiotics are not used.
- When the child is well enough to participate in group activities.

**What can be done to prevent the spread of Whooping Cough?**

- *Whooping Cough is a vaccine-preventable disease* – require up-to-date immunizations for all children in your care.
- Use good hand washing practices at all times.
- Teach children and staff to “Cover Your Cough” using a tissue (followed immediately by hand hygiene) or by covering their coughs or sneezes with their sleeves.
- Monitor all children and staff for coughs. Anyone developing a persistent cough should be referred to their health care provider.

**Who should be notified?**

Notify your local health department if someone in your program has this disease. They will provide you with further information.

**Chapter 8:**  
**Managing Chronic Medical Conditions**  
**and Special Health Care Needs**





## **Chapter 8: Managing Chronic Medical Conditions and Special Health Care Needs**

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## Managing Chronic Medical Conditions and Special Health Care Needs

### Introduction

Caregivers and teachers play an important role in the life of children with chronic medical conditions and special health care needs.

**Definition:** Children and youth with special health care needs (CYSHCN) are defined by the Department of Health and Human Services (HHS), Health Resources and Services Administration (HRSA), and the Maternal and Child Health Bureau (MCHB) as: *"Those who have or are at increased risk for a chronic physical, development, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally"*. This definition is broad and inclusive, and it emphasizes the characteristics held in common by children with a wide range of diagnoses.

Caring for children with special health care needs provides an opportunity to teach all children in the program about treating everyone with respect, helping others, and including those with differences. It is important for the caregivers and health care providers to communicate well with each other and work together to mobilize resources and strategies that will benefit the children and families in their care.

### Americans with Disabilities Act

The Americans with Disabilities Act (ADA) is a federal law, enacted in 1990, that prohibits discrimination against people with disabilities in employment, transportation, public accommodation, communications, and governmental activities. The ADA provides child care professionals with an exciting opportunity to serve children with special needs or disabilities. The law guarantees that children with disabilities cannot be excluded from "public accommodations" simply because of a disability. "Public accommodations" refers to private businesses and includes preschools, child care centers, out-of-school time programs and family child care homes.

The ADA requires that child care providers not discriminate against persons with disabilities on the basis of disability, that is, that they provide children and parents with disabilities with an equal opportunity to participate in the child care programs' services. Specifically:

- Child care programs cannot exclude children with disabilities unless their presence would pose a *direct threat* to the health or safety of others or require a *fundamental alteration* of the program.
- Child care programs have to make *reasonable modifications* to their policies and practices to integrate children, parents, and guardians with disabilities into their programs unless doing so would constitute a *fundamental alteration*.
- Child care programs must provide appropriate auxiliary aids and services needed for *effective communication* with children or adults with disabilities, when doing so would not constitute an *undue burden*.
- Child care programs must generally make their facilities accessible to persons with disabilities. Existing facilities are subject to the *readily achievable* standard for barrier removal, while newly constructed facilities and any altered portions of existing facilities must be *fully accessible*.

The ADA does not require child care programs to administer every medication, but does say that a child with special needs may not be excluded if reasonable accommodations to that child's special needs can be made.

The ADA Home Page, which is updated frequently, contains the Department of Justice's regulations and technical assistance materials, as well as press releases on ADA cases and other issues. Several settlement agreements with child care centers are also available on the Home Page. [www.usdoj.gov/ctr/ada/adahom1.htm](http://www.usdoj.gov/ctr/ada/adahom1.htm) .

There are 10 regional Disability and Business Technical Assistance Centers, or DBTAC's, that are funded by the Department of Education to provide technical assistance under the ADA. One toll-free number connects to the center in your region. **800-949-4232** (voice & TDD)

### **Benefits of Inclusion**

Inclusion is the practice of welcoming and including *all* children, regardless of ability. Inclusive child care should provide all children with the opportunities to interact with each other in an environment that offers activities adapted to meet the needs of all children. Inclusion is more than creating a physical space where all students are brought together. Programs should have well-educated staff, adaptive equipment, and space to include all of the children in their care.

Inclusion will look different for each child. All children have strengths and challenges; children with special needs may not require much more than a typically developing child. Terms used by programs and agencies to describe children with disabilities, delays, and chronic health conditions include children:

- with visual impairment or blindness
- with hearing impairment or deafness
- with physical disabilities
- with behavioral or emotional disabilities
- with cognitive delays or disabilities
- with speech-language delays or disorders
- who are developmentally disabled, developmentally delayed, or at risk for developmental delays

Families of children with special needs are searching for a place where their child will be treated as an individual with unique need, likes, dislikes, and abilities. Finding the right people and programs will enable children to learn and grow in a safe, comfortable environment. Working as a team can increase the strength of the caregiver-family bond. All children have strengths and challenges.

Here are some **tips for inclusive child care programs**:

- Consider enrolling the child on a trial basis to see if your program is able to meet the child's needs.
- Structure and consistency are keys to decreasing undesired behaviors, so be prepared to be patient and flexible. What works with one child, may not work with another; what worked last week may not work this week.

- Providers should not attempt to diagnose a child or judge them based on a diagnosis given. Child care providers will need time to learn each child's individual characteristics. Parents can help providers by sharing information about a child's likes, dislikes, need for structure and routine, etc.
- Many research studies have shown that inclusion benefits all children. Typically developing children are more open and accepting, and children with disabilities achieve greater results.
- In-home child care allows the parent to choose a caregiver who comes into their home to care for the child. All prospective in-home providers must meet all policy requirements including background checks prior to being approved by DHS to receive subsidy payments.



## Allergies

### What are allergies?

Allergy is the term used to describe the body's over-reaction to something it views as foreign or different. An allergic reaction is a response in various parts of the body to a substance that has been inhaled, eaten, injected (from stings or medicine), or that came into contact with the skin. The body reacts by releasing histamine and other substances that cause allergy symptoms. Allergy symptoms can be as minor as sneezing and itching. For some children, however, allergy symptoms can become very serious or even life-threatening.

### What are the signs or symptoms?

Allergies produce many different symptoms, including:

- Stuffy nose
- Runny nose
- Itchy, watery eyes
- Hives
- Eczema
- Wheezing
- Itching of roof of mouth
- Swelling of throat or mouth
- Swelling of the skin
- Stomach cramps

### How long does it take after the child is exposed to an allergenic substance before a reaction occurs?

Anywhere from seconds to weeks: it varies with the child, the substance, and many other factors.

### When is an allergy contagious?

Never.

### What causes allergies?

There are many things that can cause allergic reactions:

- Lotions, oils, perfumes, soaps
- Cigarette smoke
- Wool, polyesters, and other fabrics
- Foods (chocolate, nuts, cow's milk, wheat, soy, shellfish, strawberries, eggs, and others)
- Pollen from grass, flowering plants, trees, and shrubs
- Prescription and over-the-counter medications
- Animal dander
- Dust mites
- Saliva and venom from insect stings

**What should be done?**

Find out about a child's allergies at the time of enrollment. If a child has asthma, this information should be on file, along with the recommended treatment, and the name and phone number of the health care provider.

Try to be sure the child avoids the offending substance if possible. Do not give medication of any kind to an allergic or asthmatic child, unless it is recommended by the child's health care provider and you have written permission from the child's parent.

## Managing Food Allergies in Child Care

All food allergies occur when the immune system mistakes a protein in a food as a dangerous invader and produces chemicals to protect the body. This triggers an allergic reaction.

Symptoms of an allergic reaction vary, but can include:

- difficulty breathing
- swelling of the tongue and throat
- itching inside the mouth
- vomiting
- abdominal cramps and diarrhea
- hives
- eczema

**In severe cases, a whole body allergic reaction can occur, also known as anaphylaxis.**

Anaphylaxis is an extremely serious reaction and can result in loss of consciousness and even death, but it can be treated with a drug called epinephrine.

The primary way to prevent the possibility of an allergic reaction is strict avoidance of the allergy causing food. Allergic reactions can be triggered by eating the food, contact with the food, or, in some cases, by just being near the food.

Young children have the highest incidence of food allergies of any age group. The most common food allergens in young children are:

- Cows' milk
- Eggs
- Soybeans
- Wheat
- Peanuts
- Tree nuts (almonds, cashews, pecans, walnuts)
- Fish
- Shellfish

When a child has an allergic reaction, he or she tends to describe it in very different terms than adults use. Children may say things like; "My tongue/mouth itches," "It (my tongue) feels like there is hair on it", or "My tongue (or mouth) is tingling (or burning)."

Child care providers should discuss allergic reaction symptoms and how the child talks about the reaction with the child's parent. Child care providers need to be alert for the verbal cues and body language the child uses in the event of an allergic reaction.

A child could have a first allergic reaction while in your care, so staff training should be conducted by a child care health consultant or other health care provider. The training should include information on how to:

- Recognize the symptoms of an allergic reaction.
- Treat an allergic reaction.

- Prevent exposure to the food causing the allergic reaction for the child with a known food allergy.
- Develop policies and procedures and communicate the policies to parents so they are understood.
- Maintain required documentation about the child's food allergies, and the appropriate steps taken to keep the allergy causing foods away from the child.

**A treatment plan should be developed** by the child care provider and the parent with information from the child's health care provider that includes:

- What foods may trigger an allergic reaction.
- Steps for avoiding the food.
- Treatment in the event of an allergic reaction.
- When to contact emergency services.

The specifics of a child's food allergies, along with up to date documentation, should be maintained in the child's records. Any forms and correspondence between the child care provider, the child's family, and the child's health care provider should be included along with any other relevant information.

**Child care programs should have a written policy for food allergies that specifically defines the responsibilities of the child's family and the child care program in managing the food allergy.** The family's responsibilities include providing documentation of the food allergy from the child's health care provider, providing instructions that need to be taken for avoiding the allergic food, and supplying the medical provider's order for medication administration.

Management of a food allergy requires careful menu planning. Everyone involved in preparing and serving food should be vigilant about accommodating food allergies. Train staff to carefully read food labels and recognize allergens in the ingredient lists. Organize kitchen space to keep food for a food allergic child separate from other foods. Prepare foods for the child with food allergies first in order to prevent cross-contamination. Closely supervise children during meals and snacks to discourage food sharing between a child without a food allergy and one with a food allergy.

### **Field Trips and Special Events**

Young children enjoy field trips, celebrations, and parties. Planning is the key for children with food allergies. You may provide a safe food alternative or you may ask the family to bring one on those special days.

### **Resources:**

Centers for Disease Control and Prevention, *Voluntary Guidelines for Managing Food Allergies in Schools and Early Care and Education Programs*. Washington, DC: U.S. Department of Health and Human Services; 2013.

Nutrition Action: Managing Food Allergies in Childcare  
[http://www.healthychild.net/NutritionAction.php?article\\_id=507](http://www.healthychild.net/NutritionAction.php?article_id=507)

## Anemia

### What is it?

Anemia is a condition in which blood has a lower than normal number of red blood cells. Anemia can also occur if red blood cells don't contain enough hemoglobin. Hemoglobin is an iron-rich protein that gives blood its red color. This protein helps red blood cells carry oxygen from the lungs to the rest of the body.

If you have anemia, your body doesn't get enough oxygen-rich blood. As a result, you may feel tired or weak. Other symptoms include:

- Pale skin
- A fast or irregular heartbeat
- Shortness of breath
- Dizziness
- Cold hands and feet
- Headache

Anemia can be caused by many things, but the three main bodily mechanisms that produce it are:

1. **Excessive destruction of red blood cells:** sickle cell disease, toxins from liver or kidney disease
2. **Blood loss:** gastrointestinal conditions, menstruation and childbirth
3. **Inadequate production of red blood cells:** kidney disease, diabetes, rheumatoid arthritis

### Lead poisoning can lead to anemia.

- Anemia makes it easier for lead to get into the blood.
- Lead poisoning and anemia are both detected by a blood test.
- Lead poisoning and iron deficiency anemia are both preventable.
- Practice good nutrition and proper handwashing to help prevent lead poisoning and iron deficiency anemia.

Iron-deficiency anemia, and other nutritional anemias can be prevented and mild cases can be reversed by eating diets high in iron. Vitamin C helps the body use iron, so *combine foods high in iron and vitamin C* in meals and snacks.

### Some foods high in iron

Beef  
Pork  
Liver  
Tofu  
Cooked beans  
Dried fruit  
Iron-fortified cereals  
Enriched tortillas and breads  
Leafy greens

### Some foods high in vitamin C

Broccoli  
Cabbage  
Cauliflower  
Tomatoes  
Potatoes  
Bell peppers  
Oranges  
Melon  
Strawberries



## **Asthma**

Asthma is the most common chronic disease among children who use child care. It occurs in 7 to 10 percent of all preschool and school-aged children. With appropriate care at the health care provider's office, home and child care, most children with asthma do extremely well in child care settings and can participate in all activities.

Asthma is a condition in which the air passages of the lungs become temporarily narrowed and swollen and produce a thick clear mucous, causing the child to have difficulty breathing. The symptoms can disappear temporarily with treatment and/or removal from whatever is causing the asthma. Asthma cannot be cured and it has been recently learned that repeated attacks can cause permanent damage to the lungs. Asthma *can* be controlled with appropriate care.

### **Signs and symptoms of asthma**

Each child may have different asthma symptoms. The parents and health care provider should tell you what to watch for.

- Coughing (children often have a cough as an early or only symptom of asthma)
- Complaint of tightness in the chest
- Wheezing
- Rapid breathing or difficulty breathing
- Decrease in peak flow meter reading
- Unusual tiredness
- Difficulty playing, eating, or talking

### ***Indications of severe asthma episode:***

- Flaring nostrils or mouth open
- Bluish color to the lips or nails (late sign: call 911)
- Sucking in chest or neck muscles (retractions)

### **Asthma triggers**

Asthma episodes are usually started by “triggers,” events that begin an asthma attack. Each child will have different triggers. Not every child has identified triggers.

- Allergies to substances such as pollen, mold, cockroaches, animal dander, or dust mites
- Allergies to a particular food
- Infections such as colds or other viruses
- Cold air or sudden temperature or weather changes
- Exercise or overexertion
- Very strong emotions such as laughing, crying and stress

Discuss a child's asthma history with the parent at enrollment. Have parent document information regarding medications, a description of the child's triggers, symptoms, and a plan of what to do during an attack. This information should be entered on the child's Asthma Action Plan (see a sample in the Appendix).

**Procedure When Child Has an Asthma Episode**

- Remove the child from the trigger, if known.
- Remove the child from strenuous play activities (running, jumping, etc.)
- Have the child sit upright and try to keep the child calm and relaxed.
- Encourage the child to drink fluids (but nothing ice cold).
- Administer medications as indicated by the parent and health care provider.
- Notify all staff of signs that may signal an impending attack.
- If you are unsure, it is better to call the parents to take the child to the health care provider, than wait until the child is in severe distress. Every child is different and will need an individualized treatment plan.

It is a good idea to provide staff training on asthma, including signs and symptoms of asthma, administration of medications, and the asthma emergency plan.

## Attention Deficit Hyperactivity Disorder (ADHD)

**Attention Deficit Hyperactivity Disorder (ADHD)** is a condition that causes a person to be overactive and impulsive or have a hard time paying attention, or both. These behaviors may begin in early childhood or not detected until a child is older.

### Diagnosis

ADHD affects approximately 3 to 5 percent of all school-age children and is three times more common in boys than girls. Many children continue to have behaviors of ADHD as adults. ADHD affects all socioeconomic, cultural, and racial backgrounds. More than 20 percent of children with ADHD also have learning disabilities. However, having a diagnosis of ADHD or a learning disability is not related to intelligence.

Diagnosis of ADHD is made by a physician, psychiatrist, psychologist, or licensed social worker, with close collaboration and input from the parents, teachers, and child care providers. Children with ADHD demonstrate behaviors that generally fall into **three categories**: inattention, hyperactivity, and impulsivity.

**Examples of inattention** (trouble paying attention) include a child who:

- Makes careless mistakes.
- Has difficulty paying attention in tasks or play activities.
- Does not seem to listen to what is being said.
- Does not follow through or finish activities or tasks.
- Avoids or strongly dislikes routine tasks or activities.
- Is easily distracted and forgetful.

**Examples of hyperactivity** (being very active) include a child who:

- Fidgets with hands and feet, or squirms in seat.
- Has difficulty playing quietly.
- Is “on the go” or acts as if “driven by a motor”.
- Talks excessively.
- Has difficulty waiting in line or for a turn.

**Examples of impulsivity** (acting before thinking) include a child who:

- Blurts out answers to questions before they have been completed.
- Has difficulty waiting in lines or waiting for a turn.
- Interrupts or intrudes on others.

All of these behaviors are common for children at different ages and stages of development. Many 2-year-olds are “on the go” and many 3 and 4 year olds fidget when seated. For a child to be diagnosed with ADHD, some of these behaviors must have appeared before the child was 7 years of age, have lasted for at least six months, and be happening enough to cause concern at home and school, and possibly the child care setting.

### **Causes**

Scientists have not been able to determine the exact cause of ADHD, though research suggests it may be caused by a chemical imbalance or a lack of certain chemicals in the brain responsible for attention and activity. There is evidence that if one or both parents have ADHD, their children are more likely to show symptoms as well. Exposure to toxins (including drugs and alcohol during pregnancy), brain injury, and childhood illnesses may also contribute. ADHD is not caused by too much TV or poor parenting.

### **Treatment**

All interventions for children with ADHD should help build the child's sense of self-esteem. A team approach using educational, psychological, behavioral, and medical techniques is recommended and requires an effort by parents, teachers, child care and health care providers to find the right combination of responses.

Children with ADHD are typically "hands-on" learners and often respond to:

- Lower adult-child ratios
- Predictable environments
- Individualized programming
- Structure, routine, and consistency
- Motivating and interesting curricula
- Shorter activity periods
- Use of positive reinforcement
- Supplementing verbal instructions with visual aids

Counseling is an important part of the treatment plan and it may help to have the family involved in the counseling.

Physical activities can help the child with ADHD to improve coordination and self-esteem and provide an outlet for extra energy.

### **Tips for Child Care Providers:**

- Learn what you can about ADHD.
- Ask the child's parents for suggestions and tips that they have found useful at home.
- Try to be consistent with the ways the child's parents guide and manage behavior.
- Let the child take regular breaks and have access to a quiet place to regroup.
- Have clear rules and consistent schedules for the child.
- Don't forget to look for and praise appropriate behavior.

This information is from the California Childcare Health Program, [www.ucsfchildcarehealth.org](http://www.ucsfchildcarehealth.org).

## Autism Spectrum Disorders (ASDs)

### What are Autism Spectrum Disorders?

Autism spectrum disorders (ASDs) are a group of developmental disabilities caused by a problem with the brain. Children with ASDs have trouble in three core areas of their development:

- Language difficulties – especially no apparent desire to communicate
- Social interactions
- Restricted interests or behaviors that are repeated over and over again

### How common are they?

- According to the Centers for Disease Control and Prevention (CDC), 2-6 out of 1000 children has an ASD diagnosis.
- These disorders affect children of all ethnicities.
- Boys are four times more likely to be diagnosed than girls.
- The CDC estimates that in the United States up to 500,000 individuals between the ages of 0 and 21 have an ASD.
- The number of children diagnosed with autism has increased since 1990.

### What causes Autism Spectrum Disorder?

No one knows exactly what causes ASD. However, it is clear that autism is a biological brain disorder.

- Scientists believe genes play an important role in the development of autism.
- Environmental factors may also play a role.
- Studies show that **immunizations DO NOT cause ASD.**

### Early Warning Signs of ASD in infants and toddlers:

- Has limited eye contact and diminished responsiveness to others.
- Does not babble, point, or make meaningful gestures by one year of age.
- Has loss of language and /or social skills during the second year.
- Does not play “pretend” games.
- Does not respond to his or her name at one year.
- Does not smile.
- Becomes attached to unusual objects.
- Seems to be hearing impaired at times.
- Exhibits unusual repetitive behaviors like hand flapping, humming, or rocking.
- Does not use eye contact and finger pointing for the social purpose of sharing experiences with others.

### Warning Signs of ASD in pre-school aged children:

- Has difficulty with change.
- Is unable to imitate the behaviors of others.
- Has difficulty expressing emotion and responding to the emotion of others.
- Repeats or echoes words or phrases.
- Has difficulty initiating and maintaining a conversation with another child.

- Laughs, cries, or shows distress for no apparent reason.
- Has uncontrollable tantrums.
- May not want to cuddle or be cuddled.
- Has uneven gross and fine motor skills.
- Plays oddly with toys or objects.
- Has unusual reaction to sensory stimuli (sounds, smells, tastes, touches, pain).
- Has no real fear of danger.

**If you notice any of these warning signs** in a child in your care, **talk with the parents** about your concerns and suggest that a health care provider who is familiar with evaluating developmental delay evaluate the child.

Early diagnosis of ASDs can lead to early intervention services. The time to intervene is when that child is a toddler, when her young brain is still more “plastic” and can be taught new skills. The child who is unable to have social relationships or communicate his needs and feelings is at risk for becoming an adult with severe disabilities.

### **Treatment**

There is no cure for autism or ASDs. The best hope is for children to receive early and intensive intervention that focuses on teaching the child communication and social skills that allow him to connect to the world. Developmental and behavioral interventions form the core of treatment for children with ASD. Some children have special dietary requirements and some are on medication. It is important to have the parents fill out a Special Care Plan (see the Appendix) and learn about how you can provide the best care for the child.

The treatment team for children with ASDs can include:

- Developmental pediatrician
- Pediatric neurologist
- Child psychiatrist and /or child psychologist
- Occupational therapist
- Speech therapist

### **How can you assist and support the child with ASD in a child care setting?**

- Communicate with the family regularly and follow the Special Care Plan.
- Keep messages simple and direct.
- Use objects and actions along with words when communicating.
- Focus on improving the child’s communication skills and emphasize spoken language by having the child ask for something by name when possible.
- Establish a predictable environment including teachers’ language, behaviors, daily routines and classroom furnishing and materials.
- Do not rush the child; children with ASD need more time and patience from you to complete their tasks.
- Whispering may be a useful communication tool that can be used for both talking with and calming down a child with ASD.
- Do not require eye contact when talking with the child.

## Diabetes

Diabetes is a serious illness in which the body is unable to properly change sugar from food into energy. A simple sugar called glucose is the main source of energy for our body. Insulin, a hormone produced by the pancreas – a large gland behind the stomach – helps the body use the glucose for energy.

Diabetes happens when the body does not produce enough insulin (Type 1 or insulin-dependent), or use it properly (Type 2 or non-insulin dependent). As a result glucose begins to build up in the blood, creating high sugar levels in the body.

**Type 1 Diabetes** occurs when the pancreas does not produce insulin.

- It requires multiple doses of insulin every day through shots or an insulin pump.
- It accounts for 5 to 10 % of all cases of diabetes and is the most prevalent type of diabetes among children and adolescents.
- Type 1 diabetes cannot be prevented.

The three big symptoms of Type 1 Diabetes are:

1. Constant thirst
2. Frequent urination
3. Rapid weight loss

Anyone experiencing these symptoms should see their health care provider.

### **Type 2 Diabetes**

- Occurs when the pancreas does not produce enough insulin or body cells do not use insulin properly (*Insulin Resistance*).
- Is managed with diet and exercise, oral medication, and sometimes insulin.
- Increase in diagnosis of type 2 diabetes among children and adolescents in the U.S.

Symptoms of Type 2 Diabetes:

- Increased thirst and urination
- Blurry vision
- Feeling tired or ill
- Dark skin around the neck or armpits
- Frequent infections (usually yeast infections)
- Slow healing cuts and bruises
- Numbness and tingling of the hands and feet

These symptoms usually occur gradually and may go unnoticed.

Two kinds of problems occur when the body does not make insulin:

1. **Hyperglycemia**, or high blood sugar, occurs with both types of diabetes. It occurs when the body gets too little insulin, too much food, too little exercise, or with illnesses. Stress from a cold, sore throat, or other illness may increase the level of blood glucose.

Symptoms include:

- Frequent urination
  - Excessive thirst
  - Extreme hunger
  - Unusual weight loss
  - Irritability
  - Poor sleep
  - Nausea and vomiting
  - Weakness
  - Blurred vision
2. **Hypoglycemia**, or low blood sugar, is more common in people with Type 1 diabetes. It is the most common immediate health problem and is also called “insulin reaction” or “insulin shock”. It occurs when the body gets too much insulin, too little food, a delayed meal or more than the usual amount of exercise. Symptoms may include:
    - Hunger
    - Pale skin
    - Weakness
    - Dizziness
    - Headache
    - Shakiness
    - Changes in mood or behavior
    - Sweating
    - Rapid pulse

**Every child with diabetes will be different.**

- Diabetes requires a constant juggling of insulin/medication with physical activity and food.
- It is important to recognize the signs of “high” and “low” blood sugar levels.
- Children with diabetes can do the same every day activities as students without diabetes.
- A child with a diabetes emergency will need help from child care staff.

**Diabetes Management in Child Care:**

- Designate personnel trained in diabetes.
- Have access to the tools that monitor and maintain blood glucose levels.
- Assist the child with performing diabetes care tasks as needed.
- Plan for disposal of sharps and materials that come in contact with blood.
- Be prepared to recognize and treat hypo and hyperglycemia.
- Be prepared to administer insulin or glucagon as needed.
- Develop a plan for disasters and emergencies.

- Follow individualized meal plans.
- Develop plans for field trips, class parties, and extracurricular activities.
- Have an individual care plan in place for each child with a chronic condition or special health care need.

### **Diabetes Medical Management Plan (DMMP)**

The DMMP must be in place for the child's diabetes care to be implemented in the child care program. It should be:

- Individualized.
- Developed by the child's health care team, parents, and child (if applicable), and signed by the physician.
- Implemented collaboratively by the program diabetes team including:
  - Program director
  - Teacher or caregiver
  - Parent or guardian
  - Student (if developmentally appropriate)
  - Other designated personnel

### **DMMP Required Information Includes:**

- Emergency contact information
- Level of self-care
- Blood glucose monitoring
- Insulin/medication administration
- Glucagon administration
- Meal and snack schedule
- Physical activity and sports
- Recognition and treatment of hypo and hyperglycemia

### **Other Recommended areas to include:**

- Date of diagnosis
- Current health status
- Specific medical orders
- Nutrition requirements – including provisions for meals and snacks
- List of diabetes equipment and supplies needed for child care
- Location for and timing of blood sugar monitoring and treatment
- Maintenance of confidentiality and child's right to privacy

Refer to the Appendix to find:

- Diabetes Medical Management Plan
- Diabetes Management Log
- Hypoglycemia emergency care plan
- Hyperglycemia emergency care plan
- Special Health Care Plan



## Students with Diabetes

### Developmental Issues, Diabetes Care Tasks and Educational Considerations

The childcare provider can play an important role in guiding children to participate in their care to the extent appropriate for their age and developmental level. The degree of independence the child is able to participate in their care should be agreed upon by the medical provider, parent/guardian, child (if appropriate), and childcare team.

In general, childcare and after school care staff can anticipate:

1. The infant, toddler, and pre-school age child is unable to perform diabetes care tasks independently. Assistance and close supervision by the staff in diabetes care is necessary.
2. The elementary school student is able to cooperate in all diabetes care tasks, and perform independently with varying degrees of competence at school. Staff supervision in diabetes care is recommended.
3. The middle school student should be able to perform most diabetes care tasks independently under circumstances when not experiencing hypoglycemia. Periodic staff supervision is recommended.
4. The high school student most probably will perform all diabetes care tasks independently, when not experiencing hypoglycemia. Staff surveillance is recommended.

Age (years)	Developmental Issues	Diabetes Care Tasks	Educational Considerations
Below age 3 years	<p>Developing trusting relationship or bond with caregivers</p> <p>Developing the desire for greater autonomy</p>	<p>Preventing and treating hypoglycemia</p> <p>Avoid extreme fluctuations in blood glucose levels due to irregular food intake</p> <p>Toddlers may refuse to cooperate with his/her diabetes care</p>	<p>The diabetes regime is adjusted quickly to the child's dynamic growth and development</p> <p>Staff must learn the skills to provide diabetes management and perform associated diabetes tasks while meeting the developmental needs of the child</p> <p>Staff – establish a schedule</p> <p>Manage the picky eater</p> <p>Limit setting and coping with toddler's lack of cooperation</p>

<p>4 to 5 years</p>	<p>Knows likes and dislikes</p> <p>Identifies with “good” and “bad”</p> <p>Fear of intrusive procedures</p> <p>Magical thinking</p>	<p>Child can:</p> <p>Pinch own skin</p> <p>Collect urine for ketones</p> <p>Turn on glucose meter</p> <p>Help with recording data</p> <p>May begin to identify symptoms of hypoglycemia and alert adults</p>	<p>Can use guided play, play therapy, artwork to express concerns and to learn</p>
<p>6 to 7 years</p>	<p>Physically coordinated</p> <p>Concrete reasoning</p> <p>Able to share and cooperate</p>	<p>Can begin to identify carbohydrates in foods</p> <p>Can help with injections</p> <p>Can help with blood testing – able to prick own finger</p> <p>Able to activate bolus on pump with supervision</p> <p>Able to connect and disconnect insulin pump with assistance</p>	<p>May need reminders and supervision</p>
<p>8 to 10 years</p>	<p>Increased need for independence</p> <p>Does not want to be different</p> <p>Developing “scientific mind”</p> <p>Intrigued by tests</p> <p>Feelings of sadness, anxiety, isolation, and friendlessness</p>	<p>Able to participate in meal planning</p> <p>Correctly able to identify foods that fit into meal plan</p> <p>Increased independence with injections, blood and urine testing</p> <p>Able to keep records</p>	<p>Understands only immediate consequences of diabetes control, not long term</p> <p>Finds support groups, camps, individual counseling useful</p> <p>Learns best when information is presented in a fun and interesting way</p>

11 to 13 years	<p>Puberty: hormonal and physical changes may occur more for females</p> <p>Dependent versus independent struggles between parent and child, care giver and child</p> <p>Aware of body image; concerned with not being different</p> <p>More involved with peers than family</p>	<p>Can help plan meals and snacks along with starting carbohydrate counting</p> <p>Able to recognize and treat hypoglycemia</p> <p>Able to measure and inject own insulin</p> <p>Able to recognize patterns in blood glucose levels</p> <p>May need help assessing urine tests</p> <p>Able to connect and disconnect insulin pump</p> <p>Hormones of puberty can affect glucose control during this time.</p>	<p>Peer pressure begins to influence decisions</p> <p>May want to hide their disease from their peers</p>
14+	<p>Hormonal and physical changes continue</p> <p>Increased physical and social activities</p> <p>Experimentation and risk-taking behaviors</p> <p>At risk for eating disorders</p> <p>Strong peer pressure</p> <p>Values independence and self-image</p> <p>Finds assuming responsibility for self-management the most difficult task</p>	<p>Able to identify appropriate portion sizes</p> <p>Able to alter food intake in relation to blood glucose level</p> <p>Able to anticipate and prevent hypoglycemia</p> <p>Able to calculate insulin dose based on blood glucose level</p> <p>Can independently administer insulin</p> <p>Able to understand role of exercise in calculating insulin needs</p>	<p>Still needs some supervision and review regarding insulin dosing</p> <p>Knows consequences of poor diabetes control</p> <p>Learns best when educational content is pertinent to adolescent issues</p> <p>Able to learn problem solving with adults and negotiate treatment</p> <p>Likes discussion and support groups among peers</p>

## Eczema

### What is it?

Eczema is a chronic skin problem that causes dry, red, itchy skin. It is also called *atopic dermatitis*.

### Who gets eczema?

Eczema is the most common skin problem treated by pediatric dermatologists. About 65% of patients develop symptoms before age one, and about 90% before age five. Many babies outgrow eczema by age four, and some children outgrow eczema by the time they are young adults. Eczema often runs in families with a history of eczema or other allergic conditions, but it is not contagious.

### Common signs and symptoms:

- Dry, red, itchy skin and rashes. The rashes can be oozing or very dry.
- **In babies**, a rash often appears on the face and scalp.
- **In younger children**, a rash often appears in the folds of the elbows and knees.
- **In teens and young adults**, a rash often appears on the hands and feet.

There are times when the symptoms are worse (flare-ups) followed by times when the skin gets better or clears up completely (remissions).

### How to prevent flare-ups:

- Keep the child's skin moisturized.
  - Use fragrance-free moisturizers.
  - Cream or ointment is more moisturizing than lotion.
- Avoid irritants.
  - Children should wear soft fabrics such as 100% cotton clothing.
  - Use mild, unscented soap for bathing and handwashing.
  - The child's parent should be careful to use mild laundry detergent with no dyes or perfumes and no fabric softener sheet in the dryer.
- Remind child not to scratch. Scratching can make the rash worse and lead to infection.
- Parent should consult with child's health care provider about things that might trigger a flare-up.

### Treatment

The child's health care provider will recommend medication to help the child feel better and to keep the symptoms of eczema under control. Eczema medication can be given two ways:

- Topical – applied to the skin (available as creams or ointments)
- Oral – taken by mouth (available in pill or liquid form)

***Remember to develop a Special Health Care Plan with the parents and the child's health care provider so you can provide the best care possible.***

www.HealthyChildren.org (2015), *Eczema: How to Help Your Child Avoid the Itch*.

## Hearing Loss

A hearing loss, hard of hearing, hearing impairment, or deafness is a partial or total inability to hear. In children it may affect the development of language. Good hearing is necessary for a child to learn to talk. Newborn infants can hear a full range of sounds from the moment they are born (and even before)! Infants demonstrate that they hear as they quickly learn to recognize and respond to familiar voices. Hearing children turn to new sounds and their language development continually progresses.

Hearing impairment occurs when there is a problem with or damage to one or more parts of the ear. *Types of hearing loss:*

- **Conductive** results from a problem with the outer or middle ear, including the ear canal, eardrum, or ossicles. A blockage or other structural problem interferes with how sound get conducted through the ear, making sound levels seem lower. In many cases, conductive hearing loss can be corrected with medications or surgery.
- **Sensorineural** results from damage to the inner ear (cochlea) or the auditory nerve. The most common type is caused by the outer hair cells not functioning correctly. The person has trouble hearing clearly, understanding speech, and interpreting various sounds. This type of hearing loss is permanent. It may be treated with hearing aids. In most severe cases, both outer and inner hair cells aren't working correctly. This is also a type of permanent hearing loss and can be treated with a cochlear implant.
- In some other cases, the outer hair cells work correctly, but the inner hair cells or the nerve are damaged. This type of hearing loss is called **auditory neuropathy spectrum disorder**. The transmission of sound from the inner ear to the brain is then disorganized. Children with auditory neuropathy spectrum disorder can develop strong language and communication skills with the help of medical devices, therapy, and visual communication techniques.
- **Mixed** occurs when someone has both conductive and sensorineural hearing problems.
- **Central** happens when the cochlea is working properly, but other parts of the brain are not. This is a less frequent type of hearing loss and is more difficult to treat.
- **Auditory processing disorders (APD)** – not exactly a type of hearing loss because someone with APD can usually hear well in a quiet environment. Most people with APD have difficulty hearing in a noisy environment. In most cases APD can be treated with proper therapy.

### Common Causes of Hearing Loss:

- Otitis media – the medical term for an ear infection that affects the middle ear which can cause a buildup of fluid behind the eardrum. Even after the infection gets better, fluid might stay in the middle ear for weeks.
- Blockages in the ear, such as a foreign object, impacted ear wax, or dirt.
- Damage to parts of the ear – for example a hole in the eardrum from a cotton swab inserted too far or a sudden change in air pressure.
- Genetic disorders – some genetic disorders may interfere with the proper development of the inner ear and the auditory nerve.
- Injuries to the ear or head, such as a skull fracture.

- Complications during pregnancy or birth.
- Infections or illnesses.
- Medications – certain medications, such as antibiotics and chemotherapy drugs can cause hearing loss.
- Loud noise – a sudden loud noise or exposure to high noise levels over time can cause permanent damage to the tiny hair cells in the cochlea.

**Congenital** hearing loss is present at birth. **Acquired** hearing loss happens later in life and it can be sudden or progressive. About 1 in 300 children are born with hearing loss, making hearing loss one of the most common birth defects in the United States.

### **Hearing Screening and Evaluation**

In Oklahoma all babies are screened for hearing loss before they leave the hospital.

***Oklahoma State Law §63-1-543. Screening for detection of congenital or acquired hearing loss.***

A. This act shall be known and may be cited as the “**Newborn Infant Hearing Screening Act**”.

B. Every infant born in this state shall be screened for the detection of congenital or acquired hearing loss prior to discharge from the facility where the infant was born. A physician, audiologist or other qualified person shall administer such screening procedure in accordance with accepted medical practices and in the manner prescribed by the State Board of Health.

If a baby does not pass the hearing screening at birth, more testing needs to be done. The results are sent to the infant’s health care provider and to the parents. Information about where hearing can be checked is also sent to the family.

If you suspect an infant or child in your care has a hearing loss, ask the parents to have the child evaluated by a trained professional. Parents can contact their child’s health care provider or local health department.

### **Indicators of Potential Hearing Loss**

- Frequent mouth breathing
- Failure to turn toward the direction of a sound
- Delay in acquiring language
- Development of poor speech patterns
- Using gestures rather than words
- Unusual voice quality – one that is extremely high, low, hoarse, or monotone
- Difficulty understanding and following directions
- Mispronouncing many words
- Failing to respond to normal sounds and voices
- Responding to questions inappropriately

## **Human Immunodeficiency Virus / Acquired Immunodeficiency Syndrome (HIV/AIDS)**

### **What is it?**

HIV/AIDS is an infection caused by a virus called human immunodeficiency virus (HIV) that over time damages the body's immune system and other organs, and can lead to severe life-threatening illness.

### **What are the symptoms?**

When a person is first infected with HIV he or she may have no symptoms or may become ill with a fever, night sweats, sore throat, general tiredness, swollen lymph glands, and a skin rash lasting for a few days to a few weeks. These early symptoms go away by themselves. However, the virus stays in the body and causes increasing loss of immune function. This results in the body becoming unable to fight off infections. The late stage of this infection is called acquired immunodeficiency syndrome (AIDS). A person who is infected becomes potentially infectious to others for life.

### **Early symptoms of HIV infection in children include:**

- Failure to grow and gain weight
- Chronic diarrhea without a specific cause
- Enlarged liver and spleen
- Swollen lymph glands
- Chronic thrush (yeast infections)
- Skin infections
- Pneumonia
- Bacterial, viral, fungal, and parasitic infections that healthy children do not usually get

Many children are infected with HIV for years before developing any symptoms.

### **Who gets it and how?**

HIV is not easily transmitted. For HIV to spread, the virus, present in blood and other body fluids, must enter the uninfected person's blood stream through a break in the skin or through mucous membranes. In a child care setting this can only happen through blood-to-blood exchange. It cannot be transmitted through urine, stool, vomit, saliva, mucous, or sweat.

### **HIV is most commonly spread:**

- By sharing contaminated needles
- Through sexual intercourse
- By infected pregnant women to the fetus

### **Less commonly, HIV may be spread:**

- By infected mothers who breastfeed their infants
- To health care workers, primarily after being stuck with a needle containing HIV infected blood
- By exposure of open skin or mucous membranes to HIV contaminated body fluids

**Recommendations for child care providers who care for children with HIV/AIDS:**

- Protect all children and staff by strictly following special procedures for cleaning and handling blood and body fluids containing blood (standard precautions).
- Provide education to all staff members on standard precautions, including information on blood-borne pathogens and diseases and methods to control exposure, as well as accurate information about HIV/AIDS.
- Protect people with HIV from infection by communicable diseases by excluding them when there is an outbreak (upon the advice of their health care provider).
- Notify parents of all children if there is a case of chicken pox, tuberculosis, fifth disease, diarrheal disease, or measles in another child attending the program.
- Immediately refer children with HIV to their health care providers to receive appropriate preventive measures and advice about readmission to child care if they are exposed to measles or chicken pox.
- Protect the right to privacy by maintaining confidential records and by giving medical information only to persons who need to know, and with the consent of the parent.
- Help children with HIV/AIDS lead as normal a life as possible.

**To reduce the risk of spreading HIV** (or any other blood-borne infection), all child care providers should routinely follow these precautions:

- Make sure everyone uses good hand washing procedures.
- Make sure all adults use good diapering practices.
- Wear gloves when changing a diaper soiled with bloody stools.
- Wash skin on which breast milk has spilled with soap and water immediately.
- Do not allow children to share toothbrushes.
- Wear gloves when cleaning up blood and bodily fluid spills.
- Immediately clean and disinfect surfaces on which blood or bodily fluids have spilled.
- Cover open wounds on children and adults.
- Develop policies and procedures to follow in the event of an exposure to blood.

**Who should be notified?**

- Notify your local health department if someone in your program has this disease. They will provide you with further information.
- Parents and children attending group programs **do not have the “right” to know** the HIV status of other children in the program.
- Caregivers and teachers need to know when a child has an immunodeficiency, so that precautions can be taken to protect the child from infections. However, this does not require knowledge of HIV status.

## Juvenile Rheumatoid Arthritis

### What is it?

Juvenile rheumatoid arthritis, also known as juvenile idiopathic arthritis occurs when the body's immune system attacks its own cells and tissues. It's unknown why this happens, but both heredity and environment seem to play a role.

### Common signs and symptoms:

- Joints that are warm to the touch
- Swelling and tenderness to the joints
- Fever
- Rash
- Favoring one limb over another or limping
- Pain (often worse following sleep or inactivity)
- Stiffness, especially upon waking
- Inability to bend or straighten joints completely
- Decreased physical activity
- Fatigue
- Sleep problems
- Swollen lymph nodes
- Reduced appetite and weight loss

### Diagnosis

An early diagnosis and aggressive treatment are vital to preventing or slowing joint damage and preserving mobility. If you have concerns about a child be sure to discuss this with the parent and suggest they visit with the child's health care provider.

### Treatment

- There is no cure, but with prompt diagnosis and early treatment, remission is possible.
- The goal of treatment is to relieve inflammation, control pain, and improve quality of life.
- The treatment plan may include medication, exercise, eye care, dental care and proper nutrition.

### Self-care

Getting plenty of physical activity, eating well and learning how to cope with the challenges of the disease will be beneficial for children with arthritis.

- ***Remember to develop a Special Health Care Plan with the parents and the child's health care provider so you can provide the best care possible.***



## Seizure Disorders

A seizure disorder is a neurological condition usually diagnosed after a person has had at least two seizures that were not caused by some known medical condition. Brain cells communicate by using electricity. A seizure is a sudden surge of too much electrical activity in the brain.

Seizures can be caused by low blood sugar, accidental poisoning, drug overdose, an infection, a head injury, or abnormality of the brain. Some children under five years old have *febrile seizures*, which can develop when they have a fever – usually above 100.4 degrees. Seizures that happen more than once or over and over might indicate a seizure disorder. The cause of a seizure disorder is usually not known.

Children with seizure disorders usually have normal intelligence, however;

- Some children may have difficulties thinking and remembering.
- Some children may have behavioral and emotional problems that include:
  - Difficulties with concentration
  - Problems with temper control
  - Hyperactivity
  - Impulsiveness

### What does a seizure look like?

Some seizures are difficult to notice, while others are very dramatic. Seizures can be:

- *Generalized*, which affect all of the brain and cause the child to lose consciousness, and his or her body to stiffen and the limbs to shake.
- *Partial*, which affect just parts of the brain. It can take many different forms and may partly affect consciousness.

### How to help during seizures

- Stay calm!
- Keep the child from getting hurt during the seizure; help ease her to the floor.
- Remove hazards such as hard or sharp objects that can cause injury if the child falls or knocks against them.
- Loosen clothing around the child's head and neck and remove glasses.
- Gently turn the child on his side so any fluid in the mouth can drain safely.
- Talk softly to reassure the child.
- Explain to the other children what is happening – the child is having a seizure, it will be over soon, and she is not in pain.
- Keep track of when the seizure started and how long it lasted.
- Stay with the child as he comes out of the seizure to reassure him.

### What *NOT* to do during a seizure

- **DO NOT** put anything in the child's mouth.
- **DO NOT** try and restrain the child's movements.
- **DO NOT** try to bring the child out of the seizure by using cold water or shaking – it won't work and could be harmful.

- **DO NOT** give the child anything to eat or drink before fully awake.

#### **When to call 911 for emergency help**

- If the child has never had a seizure before.
- If the seizure lasts longer than five minutes in a child with a known seizure disorder.
- If the child has more than one seizure without fully regaining consciousness.

When a seizure ends, the brain begins to recover and the child returns to awareness. Be calm and reassuring because the child may be confused and frightened, and may not remember the seizure. Let the child rest or sleep as needed.

Most children with seizures take medication to control their seizures. Some medications may cause changes in the child's behavior or learning, and some can occasionally cause side effects. If you notice a change in behavior or any physical side effects such as rash, stomach pain, frequent nosebleeds, or excessive sleepiness, discuss this with the child's parent. It is also a good idea to document what you observe and when, and keep the notes on file.

#### **How to prepare your program**

- Train staff on how to identify and respond to a child having a seizure.
- Develop a *Seizure Care Plan* with the child's parent. See the Appendix for a sample.
- Have parent fill out the *Medication Administration Form*. See the form in the Appendix.
- Provide written documentation, including who is responsible to care for the child, how they have been trained, and how to store and administer any prescribed medication.
- Document every seizure in the child's *Seizure Activity Log*. See the sample log in the Appendix.
- Keep a copy of the child's *Seizure Care Plan*, *Seizure Activity Log*, and *Medication Log* of any medication given, in the child's file.

## Sickle Cell Disease

### What is it?

- Sickle cell is an inherited condition in which red blood cells change shape. Instead of being round and smooth, they form a “c” shape like a crescent moon.
- The red blood cells can get stuck in blood vessels and block blood flow, which can cause pain or swelling and keep the body from fighting infection.
- The abnormally shaped red blood cells do not live as long as regular cells, so children with sickle cell disease have a low blood count and must make new red blood cells more quickly.
- Children are born with the condition and have it for life. Some children are more severely affected; some have a milder form.

### What are some characteristics of children with sickle cell disease?

- Hand-foot syndrome – swollen hands and feet may be the first signs of sickle cell in babies. The swelling is caused by the sickle-shaped red blood cells blocking blood flow out of their hands and feet.
- Pale skin or nail beds.
- Yellow tint to the skin or whites of the eyes.
- Child is small and slender for his or her age.

Children with sickle cell may have increased absences because of complications and may need to be hospitalized for treatment. **Some complications** include:

- **Pain.** Pain can happen in any part of the body but often occurs in the hands, feet and joints. Chest pain can be especially serious.
- **Fever.** Children with sickle cell disease have a hard time fighting infection. Fevers must be evaluated by the child’s health care provider.
- **Pneumonia** can be very serious in children with sickle cell disease.
- **Splenic sequestration** is an emergency. Sickled cells can clog up the spleen and keep it from working properly (straining the blood and removing damaged cells and infection). The sickled cells can cause the spleen to back up. The spleen can get very big if that happens and sometimes break open – which is a life-threatening emergency.
- **Aplastic crisis.** Abnormal blood cells have a shorter life span, so the body needs to make new blood cells very quickly. If something like an infection prevents the body from keeping up with making new blood cells, the child can get a dangerously low blood count very quickly.
- **Strokes.** If sickled cells block the blood flow to the brain, a stroke can occur.

### What adaptations may be needed?

1. Medications. Children with sickle cell may take:
  - Penicillin from two months until five years of age (to help prevent infection)
  - Acetaminophen or ibuprofen (for pain control)
  - Extra Folic Acid (because of the red blood cells needed)
  - Special vaccinations (in addition to required)

2. Dietary considerations. Children with sickle cell disease should have at least 8 cups of water or fluid daily.
3. Physical environment
  - Hydration helps prevent sickling, so allowing the child to have a water bottle is a good idea.
  - Children with sickle cell disease may need increased bathroom breaks.
4. Be aware of what is considered an emergency

**Inform parents immediately** for:

- Fever
- Pain that does not improve with medication and rest
- Cough or mild chest pain
- Abdominal pain or swelling
- Paleness or increased tiredness
- Painful erection

**Call emergency medical services – 911** if:

- Difficulty breathing
- Seizure or loss of consciousness
- Headache or dizziness
- Change in vision
- Numbness or inability to move a body part
- Severe pain
- The spleen gets enlarged
- Prolonged erection

*Remember to develop a Special Health Care Plan with the parents and the child's health care provider so you can provide the best care possible.*

**Resources for further information**

- The Sickle Cell Information Center, [www.scinfo.org/teacher.html](http://www.scinfo.org/teacher.html)
- National Heart, Lung and Blood Institute, [www.nhlbi.nih.gov](http://www.nhlbi.nih.gov)

## Visual Impairment

Visual impairment is a term experts use to describe any kind of vision loss, whether it's someone who cannot see at all or someone who has partial vision loss. Some people are completely blind, but many others have what's called **legal blindness**. They haven't lost their sight completely but have lost enough vision that they'd have to stand 20 feet from an object to see it as well as someone with perfect vision could from 200 feet away.

Some babies have **congenital blindness**, which means they are visually impaired at birth. Congenital blindness can be caused by a number of things — it can be inherited, or caused by an infection (like German measles) that's transmitted from the mother to the developing fetus during pregnancy.

The American Foundation for the Blind estimates that 10 million people in the United States are visually impaired. **Visual impairments include:**

- **Myopia** or nearsightedness. A child who is nearsighted can see objects that are near, but has poor distance vision.
- **Amblyopia** or “lazy eye” is a decrease in the child’s vision that can happen even when there is no problem with the structure of the eye. The decrease in vision results when one or both eyes send a blurry image to the brain. The brain then “learns” to only see blurry with that eye, even when glasses are used.
- **Strabismus**, where the eyes look in different directions and do not focus simultaneously on a single point. It is commonly referred to as crossed eyes.
- **Hyperopia** or farsightedness is thought to be a normal occurrence in children under the age of five and is caused by a shortness of the eyeball. This condition often corrects itself as children mature and their eyeballs change shape. Children who are farsighted can see objects clearly at a distance, but have trouble focusing on near objects.
- **Congenital Cataracts**, where the lens of the eye is cloudy.
- **Retinopathy of Prematurity**, which may occur in premature babies when the light-sensitive retina hasn’t developed sufficiently before birth.
- **Retinitis Pigmentosa**, a rare inherited disease that slowly destroys the retina.
- **Coloboma**, where a portion of the structure of the eye is missing.
- **Optic Nerve Hypoplasia**, which is caused by underdeveloped fibers in the optic nerve and which affects depth perception, sensitivity to light, and acuity of vision.
- **Cortical Visual Impairment (CVI)**, which is caused by damage to the part of the brain related to vision, not to the eyes themselves.
- **Glaucoma** is an increase in pressure inside the eye. The increased pressure impairs vision by damaging the optic nerve. It is mostly seen in older adults, but babies may be born with the condition.

There are also numerous other eye conditions that can cause visual impairment.

It’s important to diagnose and address visual impairment in children as soon as possible. Some vision screening may occur at birth, especially if the baby is born prematurely or there’s a family history of vision problems, but baby wellness visits as early as six months should also include basic vision screening to ensure the baby’s eyes are developing and functioning as expected.

***Early signs of vision problems in infants and toddlers:***

- Jerky or fluttering eye movements.
- Eyes that wander in opposite directions or are crossed (after three months).
- Inability to focus or follow a moving object (after three months).
- Pupil of one eye larger than the other.
- Absence of a blink reflex.
- Drooping of one or both lids.
- Cloudiness on the eyeball.
- Chronic tearing.

***Signs of vision problems in older children:***

- Eyes that don't move together when following an object or a face.
- Strains to see distant objects; squints or screws up face.
- Crossed eyes, eyes that turn out or in, eyes that flutter from side to side or up and down, or eyes that do not seem to focus.
- Eyes that bulge, dance, or bounce in rapid rhythmic movements.
- Pupils that are unequal in size or that appear white instead of black.
- Repeated shutting or covering of one eye.
- Tilts head to one side.
- Unusual degree of clumsiness, such as frequent bumping into things or knocking things over.
- Frequent squinting, blinking, eye-rubbing, or face crunching, especially when there's no bright light present.
- Sitting too close to the TV or holding toys and books too close to the face.

If any of these symptoms are present, parents will want to have their child's eyes professionally examined. Early detection and treatment are very important to the child's development.

## Special Needs Rate and Certification Process

If a family is receiving DHS subsidy, you may be certified to receive a higher reimbursement rate. The child must be participating in one of the following programs:

- SoonerStart (IFSP required)
- Special Education Services (IEP required)
- Supplemental Security Income (Health Professional's statement required if the child doesn't receive SoonerStart or Special Ed services)

In order to qualify:

- The provider must have a current contract with DHS and be qualified to care for the child as determined by the program's licensing specialist.
- The child must be eligible for subsidized child care and meet the definition of a child with disabilities.
- The scoring of the special needs form must meet minimum criteria to receive the enhanced rate.
- If approved, the enhanced rate is applied the first of the month after eligibility for the special needs rate is established.

The process for applying for a special needs rate has changed effective November 1, 2014:

- Child care providers will be able to initiate the special needs rate process by accessing the revised form *Certification for Special Needs Rate for Licensed Child Care Homes and Centers 08AD006E/ADM-123* on the Provider Web at <https://www.ebt.acs-inc.com/ecc/>.
- Parents or Guardians will no longer have to contact their worker to initiate the process.
- The provider will be able to print the form and fill it out with the parent or guardian before giving it to their licensing specialist.
- Once the licensing specialist has determined eligibility for the provider, the form is scanned and emailed to the AFS Child Care Subsidy unit.
- AFS Child Care Subsidy staff score the form to determine if the child's needs qualifies for the special needs rate.

***For more information contact:***

Department of Human Services

Adult and Family Services, Child Care Subsidy

Phone: 405-521-3931

Email: [ChildCareContracts@okdhs.org](mailto:ChildCareContracts@okdhs.org)

## Training

The **child's parent** is the expert on their child and the best source for information.

### Child Care Resource and Referral Agencies

Each regional child care resource and referral agency (R&R) holds training for child care providers on different topics. You can locate your regional R&R through the Oklahoma Child Care Resource and Referral Association website at [www.oklahomachildcare.org](http://www.oklahomachildcare.org).

**The Center for Early Childhood and Professional Development** has a list of training opportunities on their website through the Statewide Training Calendar at <https://okregistry.org/>.

The **Warmline for Oklahoma Child Care Providers** offers free telephone consultation to child care providers on numerous topics of concern. Consultants can also refer providers to appropriate services and resources within their communities. The website is <http://warmline.health.ok.gov> or you can call the Warmline at **1-800-574-5437**.

### Other Resources:

- **Family Voices** is a national grassroots network of families and friends which advocates for health care services and provides information for families with children with special health care needs. [www.familyvoices.org](http://www.familyvoices.org) .
- **The Oklahoma Family Network (OFN)** is a statewide, non-profit agency that supports Oklahoma families with critically ill infants or children with special health care needs or disabilities. The website is <http://oklahomafamilynetwork.org> , or call 405-271-5972 or 877-871-5072.
- The flagship program, Oklahoma's statewide Parent-to-Parent Mentorship Program, provides informational, educational and emotional support to Oklahoma families of children with any type of special need. The Family-to-Family Health Care Information Resource Center Program provides healthcare information and education, empowering families of children with special health care needs to care for their children to support good long-term outcomes. <http://oklahomafamilynetwork.org>
- **Sooner Success** provides statewide information and referrals for Oklahomans with special needs. Sooner Success; <http://soonersuccess.ouhsc.edu/> 1-877-441-0434.
- **SoonerStart** is Oklahoma's early intervention program. It is designed to meet the needs of families with infants or toddlers with developmental delays. The website is <http://ok.gov/sde/soonerstart>.

# Chapter 9: Child Abuse





## Chapter 9: Child Abuse

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## CHILD ABUSE

### What is the law?

Oklahoma statutes define child abuse as harm or threatened harm to a child's health, safety or welfare by a person responsible for the child. This includes non-accidental physical or mental injury, sexual abuse, or neglect (Title 10, Section 7102).

- Neglect is the failure or omission to provide a child adequate food, clothing, shelter, medical care, protection, supervision, or special care made necessary by the physical or mental condition of the child. Abandonment is also a type of neglect.
- Physical abuse is non-accidental physical injury to a child under the age of 18.
- Sexual abuse, which also includes sexual exploitation, means any sexual activity or propositioning between an adult and a child for the purpose of sexually stimulating the adult, the child, or others. This can include rape, sodomy, incest, lewd or indecent acts or proposals, prostitution, obscene photography, and deliberate exposure to adult pornography or adult sex acts.
- Emotional abuse is an injury to a child's psychological growth and development resulting from incessant rejecting, criticizing, terrorizing, isolating, exploiting, corrupting, and denying emotional responsiveness.

### Scope of the problem

In Oklahoma, 138,080 children were alleged to be victims of abuse and neglect (in 2014), and 14,172 children were confirmed to be victims. It is generally accepted that this number does not represent the actual incidence of abuse and neglect.

### Who must report?

Every person, private citizen or professional who has reason to believe that a child under the age of 18 is being abused or neglected is **mandated by law** to promptly report suspected abuse to the Oklahoma Department of Human Services (DHS). Failure to do so is a misdemeanor. A person making a report, in good faith, is immune from civil or criminal liability. The name of the reporter is kept confidential by DHS.

### When to report?

A report should be made **each time** there is reasonable cause to believe that a child under 18 is being abused or neglected, or is in danger of being abused or neglected. If you are worried about a child, a trained professional at the child abuse hotline will discuss these concerns with you.

**Myth:** If I didn't hear it first hand, I don't have to report it.

**Fact:** First hand, third hand, written on a bathroom stall, or an anonymous phone call – you have to report the alleged abuse. **Every person “having reason to believe”** a child is being abused must report it, and it is not your right to assess the credibility of the source.

### **Failure to report**

**Failure to report is a misdemeanor.** Any false reporting is reported by DHS to local law enforcement for criminal investigation and upon conviction, is guilty of a misdemeanor and may be fined up to \$5,000.

### **How is abuse reported?**

**If you believe a child is being abused or neglected, you have a legal responsibility to report it to the Statewide 24-hour Child Abuse and Neglect Hotline at 1-800-522-3511.**

**Be prepared to provide specific information** including:

- Name, age, and gender of the child
- The location of the child
- Name, address, place of employment and telephone numbers of the child's parents or guardians
- A description of suspected abuse or neglect
- The current condition of the child

Child welfare workers are responsible for investigating child abuse allegations. Law enforcement officials will also investigate when a crime may have been committed. These people are trained to investigate allegations. Unless you are a professional trained to handle child abuse allegations, try to keep from interviewing the child too much about the situation; remain calm and keep questions to a minimum while still providing a welcoming environment if information is offered.

If DHS become involved in a child abuse/neglect investigation the child may be asked the same questions more than once by more than one person and may get confused on what they think they should say. Remember you are only reporting suspected child abuse and/or neglect. Leave the true interviewing to the professionals.

### **When a child tells you about abuse**

There may be times when children or adolescents tell you, directly or indirectly, about abuse in their family. Remember how difficult it is for children to talk about their abuse, especially as they may think it will get them or their family into trouble. Therefore, it is very important for you to handle their disclosure with sensitivity.

**In responding to a child, it will be helpful if you:**

- Provide a private time and place to listen.
- Reassure them that they have done the right thing by telling.
- Inform them that you are required by law to report the abuse.
- Do not express shock or criticize their family.
- Use their vocabulary to discuss body parts.
- Reassure the child that the abuse is not their fault, that they are not bad or to blame.
- Determine their immediate need for safety.
- Let the child know what will happen when you report.

**Remember**

Many children are too young to tell about their abuse. They depend on you to notice and report. As a child care provider, you are in an excellent position to identify suspected child abuse. Often you are with the children every day. You see them and observe their behavior. You are aware when children are behaving differently, may be ill, frightened, or in pain for a variety of reasons. You might see clues that alert you to the possibility of child abuse. The following information will describe the four major forms of abuse and clues that may help you recognize the abuse.

## **Types of Abuse**

### **Child Neglect**

**Neglect is the most common form of maltreatment.** Neglect is a failure to provide for the child's basic needs such as food, clothing, shelter, medical care, education or proper supervision. In Oklahoma 17,421 substantiated cases of neglect were counted in 2013. It is generally accepted that this number does not represent the actual incidence of abuse and neglect.

#### **Indicators may include:**

- Child consistently arrives hungry, begs for food.
- Child has untreated lice, a distended stomach, and is emaciated.
- Child has poor hygiene: matted hair, dirty skin, or severe body odor.
- There is evidence that parents have left the child alone, or have left a child to care for younger siblings when the child is too young to do so.
- Child has unmet medical or dental care needs.
- Child is tired, listless, and continually falling asleep.
- Child is often absent or tardy.
- Child is always watchful, as though waiting for something bad to happen.

#### **Caretaker characteristics may include:**

- Evidence of apathy or hopelessness.
- Consistent failure to keep appointments.
- Appears to be suffering from mental illness, development disability, drug or alcohol use so severe that it interferes with ability to provide basic needs.

## **Emotional Abuse**

Emotional abuse is a pattern of behavior that hurts a child's emotional, psychological, and social development and sense of self-worth. This may include constant criticism, belittling, rejecting, threats, withholding affection, constantly treating siblings unequally; or a persistent lack of concern for the child's welfare. It can also include bizarre or cruel forms of punishment. If a child is being physically or sexually abused, he or she may be emotionally abused as well.

### **Physical & behavioral indicators may include:**

- Lags in physical development
- Failure-to-thrive
- Low self-esteem
- Severe depression or anxiety
- Sucking, biting, rocking in older children
- Behavioral extremes such as compliant, passive, demanding, antisocial, destructive, overly needy
- Self-destructive, attempted suicide

### **Caretaker characteristics may include:**

- Seems unconcerned about child's problems.
- Withholds affection or love.
- Has impossible expectations or makes unreasonable demands of child.

## **Physical Abuse**

Physical abuse is intentional injury to a child under the age of eighteen by a parent or caretaker. It may include beatings, shaking, burns, human bites, strangulation or immersion in scalding water with resulting bruises and welts, broken bones, scars or internal injuries.

Physical child abuse is typically a pattern of behavior that is repeated over time but can also be a single physical attack. It occurs when a parent or other person injures or causes a child to be injured, tortured or maimed, or when unreasonable force is used upon a child. Abuse may also result from unnecessarily harsh discipline or from punishment that is too severe.

In Oklahoma, 6,984 substantiated cases of abuse were counted in 2013. It is generally accepted that this number does not represent the actual incidence of abuse and neglect.

### **Myths**

- The majority of parents who abuse their children are mentally ill.
- Physical abuse only occurs in lower socioeconomic families.
- Young children have frequent accidents that result in broken bones.
- A physician's opinion is needed before a report of physical abuse can be made.
- Only children under age sixteen can be reported as physically abused.
- Children who are being abused by their parents will ask someone for help.

### **Facts**

- Fewer than ten percent of abusive parents have a severe mental disorder.
- Reports of physical abuse have been confirmed in all socioeconomic levels.
- Many broken bones in children under age two are the result of intentional injury.
- Proof of injury is not necessary to make a request for investigation.
- Physical abuse to any child under age eighteen should be investigated.
- Children are usually afraid to talk about their injuries or are too young to ask for help.

### **Physical indicators may include:**

- Unexplained bruises and welts are the most frequent evidence found and are often on the face, torso, buttocks, back, or thighs. They can reflect the shape of the object used (electric cord, belt buckles) and may be in various states of healing.
- Unexplained burns are often on palms, soles, buttocks, and back and can reflect the pattern indicative of cigarette, cigar, electrical appliance, hot water, or rope burn.
- Fractures (broken bones) that do not fit the story of how an injury occurred.

### **Behavioral indicators may include:**

- Backing away or ducking when approached by an adult.
- Requests or feels deserving of punishment.

- Afraid to go home and/or request to stay in school, child care, etc.
- Overly shy, tends to avoid physical contacts with adults, especially parents.
- Displays behavioral extremes (withdrawal or aggressiveness).

**Caretaker characteristics may include:**

- Uses harsh and inappropriate discipline.
- Offers illogical, contradictory, or no explanation for injury.
- States child is bad, stupid, different, etc.
- Attempts to conceal child's injury.
- Has unrealistic expectations beyond child's age or ability.

**Sexual Abuse**

Child sexual abuse refers to any sexual act with a child by an adult or older child. It includes behaviors such as fondling or rubbing the child's genitals, penetration, rape, sodomy, verbal stimulation, indecent exposure, voyeurism, and involving a child in prostitution or the production of pornography. Incest is sexual abuse that occurs within a family. The abuser may be a parent, stepparent, grandparent, sibling, cousin or other family or household member.

In Oklahoma 831 cases of sexual abuse were counted in 2013. It is generally accepted that this number does not represent the actual incidence of abuse and neglect. Current research indicates that one in four girls and one in seven boys will be sexually abused by the age of eighteen.

Child sexual abuse is more typically an ongoing relationship that can last up to several years. Verbal threats and coercion are frequently used to force children to participate and keep the abuse a secret.

**Myths**

- Sex offenders can be easily identified, as they are strangers who offer rides or candy to children.
- Most sexual abuse victims are teenagers who can protect themselves from exploitation.
- Children often lie about being sexually abused.
- Incest offenders only molest children in their own families.

- The lack of physical violence in child sexual abuse means children are willing participants.
- Sex offenders are severely mentally disturbed, homosexual, or mentally retarded.

### **Facts**

- Eighty to ninety percent of sex offenders are known to the child; they are family members, friends, neighbors, and babysitters.
- Children of all ages are sexually abused; over 1/3 of the victims are five years old or younger.
- Children typically do not have the experience or vocabulary to accurately describe adult sexual activity.
- Research indicates that many incest offenders also molest children outside their families.
- Verbal threats and coercion are frequently used to force children to participate and keep the abuse secret.
- Many sex offenders appear to be responsible and respectable citizens. They may be married and appear to function well in many areas of life.

### **How to recognize child sexual abuse**

Children are unable to give informed consent to sexual activity. Many children do not report their abuse and rely on adults to be aware of specific behavioral and physical indicators. A child who persistently shows several of the following characteristics may be experiencing sexual abuse. Remember, one of the most reliable indicators of child sexual abuse is the child's verbal disclosure.

#### **Behavior indicators may include:**

- Excessive masturbation in young children
- Sexual knowledge or behavior beyond that expected for the child's developmental level
- Depression, suicidal gestures
- Chronic runaway
- Fearfulness, anxiety
- Frequent psychosomatic complaints, such as headaches, backaches, and stomachaches

- Drug or alcohol abuse
- Avoidance of undressing or wearing extra layers of clothes
- Sudden avoidance of certain familiar adults or places
- Decline in school performance
- Sleep disturbance

**Physical indicators may include:**

- Pain, swelling, or itching in the genital area
- Bruises, bleeding, discharge in the genital area
- Sexually transmitted diseases
- Pregnancy in young adolescents
- Frequent, unexplained sore throats, yeast or urinary infections

**Caretaker characteristics may include:**

- Extremely protective or jealous of child.
- Encourages child to engage in prostitution or sexual acts.
- Non-abusing caretaker may be frequently absent thereby allowing abuser access to child.

**Remember Your Responsibility**

As an adult working with children you may see bruises and bumps every day; which is understandable because children, especially young children, play rough and can be uncoordinated at times.

If a parent can't (or won't) explain the injury at the morning health check, and the child is reluctant to explain where the injury came from, it's better to be safe than sorry and make a report. **YOU MAY BE THE ONLY VOICE THE CHILD HAS.**

Oklahoma State Statute requires EVERY person who has reason to believe a child under 18 is being abused or neglected, or is in danger of being abused or neglected, to promptly report the suspicion. Failure to report child abuse is a misdemeanor offense. A person should promptly **contact the statewide toll-free Child Abuse Hot Line at 1-800-522-3511.**



## **Caring for Children who have been Abused and Neglected**

Abused children can be at risk for cognitive delays and emotional difficulties. The lasting effects are massive and can lead into adulthood. Caregivers take on much responsibility when working with children who have been abused or neglected. It is possible to help children find healing after a traumatic experience but there are some issues the children may be dealing with as a result of the abuse:

- Aggression
- Developmental Delays
- Emotional issues (depression or anxiety)
- Inappropriate modeling (overly sexual/playing the parent)
- Odd Eating behaviors
- Odd Soothing behaviors (scratching or rocking themselves)

Providing a calm, safe environment for children and receiving training from professionals is the first step in working with children with a complicated past. Available resources include:

- The National Child Traumatic Stress Network:  
<http://www.nctsn.org/resources/audiences/parents-caregivers/what-is-cts>
- Child Welfare Information Gateway: <https://childwelfare.gov/>
- The National Council for Adoption’s Article “Supporting Maltreated Children: Countering the Effects of Neglect and Abuse”  
[https://www.adoptioncouncil.org/images/stories/documents/NCFA\\_ADOPTION\\_ADVOCATE\\_NO48.pdf](https://www.adoptioncouncil.org/images/stories/documents/NCFA_ADOPTION_ADVOCATE_NO48.pdf)
- Child Maltreatment: Past, Present, and Future:  
[https://www.childwelfare.gov/pubs/issue\\_briefs/cm\\_prevention.pdf](https://www.childwelfare.gov/pubs/issue_briefs/cm_prevention.pdf)
- Long-Term Consequences of Child Abuse and Neglect:  
[https://www.childwelfare.gov/pubs/factsheets/long\\_term\\_consequences.pdf](https://www.childwelfare.gov/pubs/factsheets/long_term_consequences.pdf)
- Preventing Child Abuse and Neglect:  
<https://www.childwelfare.gov/pubs/factsheets/preventingcan.pdf>
- Understanding the Effects of Maltreatment on Brain Development:  
[https://www.childwelfare.gov/pubs/issue\\_briefs/brain\\_development/brain\\_development.pdf](https://www.childwelfare.gov/pubs/issue_briefs/brain_development/brain_development.pdf)

### **Helpful Tips for Caring for Children Who Have Been Abused and Neglected**

- Listen.
- Treat with respect.
- Provide a calm, safe environment.
- Encourage creativity and fun activities.
- Write down and explain rules.
- Be consistent with the consequences of not following the rules.
- Be there! Prove that some adults can be trusted.
- Set an example. Remember every word you say and every action you take – you are modeling behavior for all of the children in your care.



## Child Abuse Prevention

### When the Baby Won't Stop Crying

Crying is an important means of communication for babies during early infancy. At this stage in their development, infants depend almost entirely on caregivers to meet their needs. As a result, infant crying can assume an important role in ensuring the survival, health and development of the child.

Persistent crying that seems to have no reason can make parents and caregivers feel worried, upset, or even out of control. It's important to remember to not take the baby's crying personally and **NEVER SHAKE THE BABY! Shaking an infant can cause blindness, brain damage or even death!**

**The Period of PURPLE Crying** is a new way to help parents and caregivers understand the time in a baby's life which is a normal part of every infant's development. It is confusing to be told your baby "has colic" because it sounds like an illness or a condition that is abnormal. When the baby is given medication to treat symptoms of colic, it reinforces the idea that there is something wrong with the baby, when in fact, the baby is going through a very normal developmental phase.

The Period of PURPLE Crying begins at about 2 weeks of age and continues until about 3-4 months of age. There are other common characteristics of this phase, which are described in the PURPLE acronym. *All babies go through this period.* It is during this time that some babies can cry a lot and some far less, but they all go through it. When babies are going through this period they seem to resist soothing. Nothing helps. Even though certain soothing methods may help when they are simply fussy or crying, bouts of inconsolable crying are different. Nothing seems to soothe them.

During this phase of a baby's life they can cry for hours and still be healthy and normal. Parents often think there must be something wrong or they would not be crying like this. However, even after a check-up from the doctor which shows the baby is healthy they still go home and cry for hours, night after night. Often parents say their baby looks like he or she is in pain. They think they must be, or why would they cry so much. Babies who are going through this period can act like they are in pain even when they are not.

The acronym PURPLE is used to describe specific characteristics of an infant's crying during this phase and lets parents and caregivers know that what they are experiencing is normal, and although frustrating, is simply a phase in the child's development and that it will pass. This is only temporary and will come to an end.

Period of PURPLE Crying: <http://www.purplecrying.info/> AAA

## THE LETTERS IN PURPLE STAND FOR

**P**

### PEAK OF CRYING

Your baby may cry more each week, the most in month 2, then less in months 3-5

**U**

### UNEXPECTED

Crying can come and go and you don't know why.

**R**

### RESISTS SOOTHING

Your baby may not stop crying no matter what you try.

**P**

### PAIN-LIKE FACE

A crying baby may look like they are in pain, even when they are not.

**L**

### LONG LASTING

Crying can last as much as 5 hours a day, or more.

**E**

### EVENING

Your baby may cry more in the late afternoon and evening.

**THE WORD PERIOD MEANS THAT  
THE CRYING HAS A BEGINNING AND AN END**

## **Working with Families – the Strengthening Families Protective Factors**

The Center for the Study of Social Policy (CSSP), introduced the Strengthening Families Approach and Protective Factors Framework in 2003.

Strengthening Families™ is a research-informed approach to:

- Increase family strengths
- enhance child development
- reduce the likelihood of child abuse and neglect

Rather than identifying risk factors for maltreatment and addressing the problems and deficiencies of the primary caregiver, this framework focuses on strengthening protective factors and building family and social networks to reinforce the ability of parents to care for their children.

### **Early childhood programs can help prevent child abuse and neglect by using the following program strategies:**

- Facilitate friendships and mutual support
- Strengthen parenting
- Respond to family crises
- Link families to services and opportunities
- Facilitate children’s social and emotional development
- Observe and respond to early warning signs of child abuse and neglect
- Value and support parents

These program strategies build the following **protective factors**, which are known to reduce child abuse and neglect.

- **Parental resilience:** managing stress and functioning well when faced with challenges, adversity, and trauma.
- **Social connections:** having a sense of connectedness with constructive, supportive people and institutions.
- **Knowledge of parenting and child development:** understanding parenting best practices and developmentally appropriate child skills and behaviors.
- **Concrete support in times of need:** identifying, accessing, and receiving needed adult, child, and family services.
- **Social and emotional competence of children:** forming secure adult and peer relationships; experiencing, regulating, and expressing emotions.

For more information about Strengthening Families visit the CSSP website:

<http://www.cssp.org/reform/strengtheningfamilies>



**Appendices:  
Handouts, Resources  
and Sample Forms**





## Appendices: Handouts, Resources, and Sample Forms

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# Biting



Biting is a common but upsetting behavior of toddlers and two year olds. Because it is upsetting and potentially dangerous, it is important for parents to address biting when it occurs.

## When a child bites another child

Intervene immediately between the child who bit and the bitten child. Stay calm; don't overreact, yell or give a lengthy explanation.

**Use your voice and expression to show that biting is not acceptable.** Look into the child's eyes and say calmly but firmly "No biting people." Point out how the biter's behavior affected the other person. "You hurt him and he's crying." Encourage the child who was bitten to tell the biter "You hurt me." Encourage the child who bit to help the other child by getting the ice pack, etc.

**Offer the bitten child comfort and first aid.** Wash broken skin with warm water and soap. Observe standard precautions if there is bleeding. Apply an ice pack or cool cloth to help prevent swelling. If the bitten child is a guest, tell the parents what happened. Suggest the bitten child be seen by a health care provider if the skin is broken or there are any signs of infection (redness or swelling).

## Preventing biting

**Reinforce desired behavior.** Notice and acknowledge when you like what your child is doing, especially for showing empathy or social behavior, such as patting a crying child, offering to take turns with a toy or hugging gently. Do not label, humiliate or isolate a child who bites.

**Discourage play which involves "pretend" biting, or seems too rough and out of control. Help the child learn to communicate by using words.**



Provided by California Childcare Health Program  
For more information, please contact:  
Healthline 1-800-333-3212

Distributed by:

## Why do children bite and what can we do?

Children bite for many different reasons, so in order to respond effectively it's best to try and find out why they are biting. Keep notes over several days on when, where and why your child bites. This may help you see a pattern and understand how to intervene.

**If your child experiments by biting,** immediately say "no" in a firm voice, and give him a variety of toys to touch, smell and taste and encourage sensory-motor exploration.

**If your child has teething discomfort,** provide cold teething toys or safe, chewy foods.



**If your child is becoming independent,** provide opportunities to make age-appropriate choices and have some control (the bread or the cracker, the yellow or the blue ball), and notice and give positive attention as new self-help skills and independence develop.

**If your child is using muscles in new ways,** provide a variety of play materials (hard/soft, rough/smooth, heavy/light) and plan for plenty of active play indoors and outdoors.

**If your child is learning to play with other children,** try to guide behavior if it seems rough (take the child's hand and say, "Touch Jorge gently—he likes that") and reinforce pro-social behavior (such as taking turns with toys or patting a crying child).

**If your child is frustrated in expressing his/her feelings, needs and wants,** state what she is trying to communicate ("you feel mad when Ari takes your truck" or "you want me to pay attention to you").

**If your child is threatened by new or changing situations** such as a parent returning to work, a new baby, or parents separating, provide special nurturing and be as warm and reassuring as possible, and help him talk about feelings even when he says thing like "I hate my new baby."

- Consult with a professional if your child seems to be acting out due to unusual stress.
- If the child continues biting over several weeks or does not seem to care about the consequences, seek professional help. It is unusual for a preschool age (3-5 year old) child to continue to bite and he/she needs to be evaluated for developmental concerns.

by Cheryl Oku, Infant/Toddler Specialist



# Carbon Monoxide Fact Sheet

## What is carbon monoxide?

Carbon monoxide (CO) is a very dangerous gas that people cannot see, taste or smell. It is made from incomplete burning of materials such as gasoline, charcoal and wood.

## Why is carbon monoxide so dangerous?

Too much CO in the blood will result in death. When a person breathes CO, it goes into the organs instead of oxygen. People literally suffocate from the inside out. Hundreds of people die each year from breathing CO.

## Where does CO come from?

Kerosene or propane

Space heaters

Furnaces

Gas oven or range top

Gas water heater

Gas clothes dryer

Gasoline-powered

engines

Charcoal grills

Fireplace/chimney

## What are the symptoms of CO poisoning?

CO is sometimes called "The Great Imitator." This is because the minor symptoms are like the flu. It is sometimes hard to tell the difference between minor CO symptoms and the flu. This is one of the reasons CO detectors are so important.

### Minor Symptoms

Headache

Nausea

Vomiting

Irritability

Chest pain in heart

patients

Blurred vision

### Moderate Symptoms

Minor Symptoms **plus**

Drowsiness

Weakness

Dizziness

Fainting

Severe headache

Difficulty thinking

### Severe Symptoms

Moderate Symptoms

**plus**

Increased heart rate

Blackout spells

Permanent brain damage

Coma

Convulsions/seizure

DEATH

A person does not always notice minor symptoms. In just one night, a person can have severe symptoms or even die from CO poisoning. This is why it is very important to have CO detectors properly installed in your home.

## **When would I need to see a physician?**

- Any person exposed to CO and has moderate or severe symptoms (see above) should see a physician right away.
- Infants and elderly adults who have been exposed to CO should see a doctor, even if they have no symptoms.
- People who have heart problems should see a doctor if they have been exposed to CO.
- Pregnant women should see a doctor right away if exposed to CO. The fetus can suffer harm even if the woman has no symptoms.

## **How can I protect myself from CO poisoning?**

- Place a CO detector near the sleeping area.
- Never use oven or gas ranges for heating purposes.
- All fuel burning appliances, furnaces, venting and chimney systems should be checked annually by a professional. CO detectors are not a substitute for yearly checks.
- Never use fuel-burning appliances, like a barbeque grill, in a confined area such as the garage or basement.
- Never burn charcoal inside your home, cabin, recreation vehicle or tent.
- Never leave the car running in the garage. Car exhaust contains CO. It can enter the home – even if the garage door is up.

## **Where do I put a CO detector?**

All homes should have a CO detector near the sleeping areas. Other CO detectors should be put on each level of the house and near living areas. A CO detector should not be placed within 15 inches of heating or cooking appliances or in a humid area, such as the bathroom. CO detectors should be placed at knee level (sleeping height) up to chest level. If it is a combination smoke/CO detector, it should be placed ceiling high to ensure smoke is detected.

## **What do I do if a carbon monoxide detector sounds?**

- Everyone should leave the house and get outside right away.
- Go to a doctor right away if anyone has had moderate or severe symptoms, has a history of heart problems, is pregnant, or if an infant has been exposed.
- Call your local gas company, fire department or appliance repair shop to come and find the source of the CO.
- DO NOT GO BACK INSIDE until the CO leak has been found and fixed.

09/2008

**Oklahoma Poison Control Center**  
**1-800-222-1222**  
**OKC Area (405) 271-5454**  
**[www.oklahomapoison.org](http://www.oklahomapoison.org)**

# Child Care Meal Pattern

## Breakfast

Select All Three Components for a Reimbursable Meal

<b>Food Components</b>	<b>Ages 1-2</b>	<b>Ages 3-5</b>	<b>Ages 6-12<sup>1</sup></b>
<b>1 milk<sup>2</sup></b> fluid milk	1/2 cup	3/4 cup	1 cup
<b>1 fruit/vegetable</b> juice, <sup>3</sup> fruit and/or vegetable	1/4 cup	1/2 cup	1/2 cup
<b>1 grains/bread<sup>4</sup></b> bread or cornbread or biscuit or roll or muffin or cold dry cereal or hot cooked cereal or pasta or noodles or grains	1/2 slice 1/2 serving 1/4 cup 1/4 cup 1/4 cup	1/2 slice 1/2 serving 1/3 cup 1/4 cup 1/4 cup	1 slice 1 serving 3/4 cup 1/2 cup 1/2 cup
<p><sup>1</sup> Children age 12 and older may be served larger portions based on their greater food needs. They may not be served less than the minimum quantities listed in this column.</p> <p><sup>2</sup> Milk served must be low-fat (1%) or non-fat (skim) for children ages 2 years and older and adults.</p> <p><sup>3</sup> Fruit or vegetable juice must be full-strength.</p> <p><sup>4</sup> Breads and grains must be made from whole-grain or enriched meal or flour. Cereal must be whole-grain or enriched or fortified.</p>			

## Child Care Meal Pattern

### Lunch or Supper

Select All Four Components for a Reimbursable Meal

<b>Food Components</b>	<b>Ages 1-2</b>	<b>Ages 3-5</b>	<b>Ages 6-12<sup>1</sup></b>
<b>1 milk<sup>2</sup></b> fluid milk	1/2 cup	3/4 cup	1 cup
<b>2 fruits/vegetables</b> juice, <sup>3</sup> fruit and/or vegetable	1/4 cup	1/2 cup	3/4 cup
<b>1 grains/bread<sup>4</sup></b> bread or cornbread or biscuit or roll or muffin or cold dry cereal or hot cooked cereal or pasta or noodles or grains	1/2 slice 1/2 serving 1/4 cup 1/4 cup 1/4 cup	1/2 slice 1/2 serving 1/3 cup 1/4 cup 1/4 cup	1 slice 1 serving 3/4 cup 1/2 cup 1/2 cup
<b>1 meat/meat alternate</b> meat or poultry or fish <sup>5</sup> or alternate protein product or cheese or egg or cooked dry beans or peas or peanut or other nut or seed butters or nuts and/or seeds <sup>6</sup> or yogurt <sup>7</sup>	1 oz. 1 oz. 1 oz. 1/2 1/4 cup 2 Tbsp. 1/2 oz. 4 oz.	1½oz. 1½ oz. 1½ oz. 3/4 3/8 cup 3 Tbsp. 3/4 oz. 6 oz.	2 oz. 2 oz. 2 oz. 1 1/2 cup 4 Tbsp. 1 oz. 8 oz.

<sup>1</sup> Children age 12 and older may be served larger portions based on their greater food needs. They may not be served less than the minimum quantities listed in this column.

<sup>2</sup> Milk served must be low-fat (1%) or non-fat (skim) for children ages 2 years and older and adults.

<sup>3</sup> Fruit or vegetable juice must be full-strength.

<sup>4</sup> Breads and grains must be made from whole-grain or enriched meal or flour. Cereal must be whole-grain or enriched or fortified.

<sup>5</sup> A serving consists of the edible portion of cooked lean meat or poultry or fish.

<sup>6</sup> Nuts and seeds may meet only one-half of the total meat/meat alternate serving and must be combined with another meat/meat alternate to fulfill the lunch or supper requirement.

<sup>7</sup> Yogurt may be plain or flavored, unsweetened or sweetened.

## Child Care Meal Pattern

<b>Snack</b>			
Select Two of the Four Components for a Reimbursable Snack			
<b>Food Components</b>	<b>Ages 1-2</b>	<b>Ages 3-5</b>	<b>Ages 6-12<sup>1</sup></b>
<b>1 milk<sup>2</sup></b> fluid milk	1/2 cup	1/2 cup	1 cup
<b>1 fruit/vegetable</b> juice, <sup>3</sup> fruit and/or vegetable	1/2 cup	1/2 cup	3/4 cup
<b>1 grains/bread<sup>4</sup></b> bread or cornbread or biscuit or roll or muffin or cold dry cereal or hot cooked cereal or pasta or noodles or grains	1/2 slice 1/2 serving 1/4 cup 1/4 cup 1/4 cup	1/2 slice 1/2 serving 1/3 cup 1/4 cup 1/4 cup	1 slice 1 serving 3/4 cup 1/2 cup 1/2 cup
<b>1 meat/meat alternate</b> meat or poultry or fish <sup>5</sup> or alternate protein product or cheese or egg <sup>6</sup> or cooked dry beans or peas or peanut or other nut or seed butters or nuts and/or seeds or yogurt <sup>7</sup>	1/2 oz. 1/2 oz. 1/2 oz. 1/2 1/8 cup 1 Tbsp. 1/2 oz. 2 oz.	1/2 oz. 1/2 oz. 1/2 oz. 1/2 1/8 cup 1 Tbsp. 1/2 oz. 2 oz.	1 oz. 1 oz. 1 oz. 1/2 1/4 cup 2 Tbsp. 1 oz. 4 oz.
<p><sup>1</sup> Children age 12 and older may be served larger portions based on their greater food needs. They may not be served less than the minimum quantities listed in this column.</p> <p><sup>2</sup> Milk served must be low-fat (1%) or non-fat (skim) for children ages 2 years and older and adults.</p> <p><sup>3</sup> Fruit or vegetable juice must be full-strength.</p> <p><sup>4</sup> Breads and grains must be made from whole-grain or enriched meal or flour. Cereal must be whole-grain or enriched or fortified.</p> <p><sup>5</sup> A serving consists of the edible portion of cooked lean meat or poultry or fish.</p> <p><sup>6</sup> One-half egg meets the required minimum amount (one ounce or less) of meat alternate.</p> <p><sup>7</sup> Yogurt may be plain or flavored, unsweetened or sweetened.</p>			

**Children and Divorce: Possible Issues and Ways to Help**

<b>Age</b>	<b>Possible Issues:</b>	<b>Possible Changes:</b>	<b>Ways to Help:</b>
0-18 months	consistency of caregivers, environment, and routine; emotional connection with caregiver; nurturing and love	changes in sleeping or eating; clingy behavior; difficulty separating	try to maintain consistency in people and routines; change routines very gradually; avoid angry expressions and emotional outbursts in front of the baby
18 mos.-3 years	consistency of caregivers, environment, and routine; fear absent parent has disappeared; nurturing and love; security (who will take care of me?)	increased crying; trouble getting to sleep/nightmares; changes in toileting habits; wanting to be fed by parent; increased displays of anger (temper tantrums, hitting, etc.); clinging to adults or security objects	give love and affection; try to maintain consistency in people and routines; reassure the child that he or she will be cared for; provide clear and concrete explanation of changes; provide opportunities for the child to express feelings through words and play; avoid angry expressions and emotional outbursts and don't fight in front of the child
3-5 years	fear of being abandoned and rejected; doubts he/she is loveable (did Mommy/Daddy leave because I'm not good enough?); self-blame for what happened (did I cause this because I was bad?)	regression in sleeping/eating/talking; clingy behavior & difficulty with separation; increased anger; increased passivity (over-compliance)	*see 18 mos. – 3 yrs.
6-8 years	yearning for absent parent; fantasies about parents getting back together; loyalty conflicts; concern about parent's well-	sadness, grief, crying, sobbing, withdrawal; fear of losing relationship with parent; fear of losing order in their lives;	provide verbal assurances (Mom and Dad will continue to take care of them); assure them they will continue to see both

	being; guilt that they are responsible for the separation	feelings of being deprived; anger and increased aggression; difficulty playing and experiencing pleasure	parents (if this is the case); give child permission to love the other parent; don't criticize the other parent to the child; don't put the child "in the middle"
9-12 years	may see things as black and white: one parent is right; the other is wrong; may feel shame or embarrassment about parents' separation; may feel the separation threatens their own identity; may feel need to overcome a sense of powerlessness; may feel loyalty conflicts	physical complaints (headache, fatigue, stomach ache); intense anger, especially at parent they see as to blame; alignment with one parent against the other; difficulty with peers, difficulty playing and experiencing pleasure	listen to child's feelings and complaints without taking sides or judging; don't criticize the other parent to the child; encourage the child to see good in the other parent; don't fight in front of the child; say positive things about the other parent occasionally; don't pressure the child to take sides, support the child's contact with the other parent (if this is possible)



## Health & Safety Notes

# Safe and Effective Cleaning, Sanitizing and Disinfecting

### What are cleaning, sanitizing and disinfecting?

Sometimes these terms are used interchangeably, but they are not the same. They have different outcomes which the United States Environmental Protection Agency (EPA) defines as follows:

- ▶ To clean means to physically remove dirt, debris and sticky film from the surface by scrubbing, washing, wiping and rinsing. You can clean with a mild soap or detergent and water.
- ▶ To sanitize means to apply a product that reduces germs to safer levels. Sanitizing surfaces destroys enough germs to reduce the risk of becoming ill from contact with those surfaces.
- ▶ To disinfect means to apply a product that destroys nearly all germs when applied to hard, nonporous surfaces. Disinfecting is a higher level of germ killing.

### What should I sanitize?

Sanitizing is recommended for food surfaces (dishes, utensils, cutting boards, high chair trays) and other objects intended for the mouth like pacifiers and teething toys.

### What should I disinfect?

Disinfecting is recommended for hard non-porous surfaces such as toilets, changing tables, and other bathroom surfaces; blood spills and other potentially infectious body fluids like vomit, urine and feces.

### How do I know which product to use?

Sanitizing and disinfecting products are called antimicrobials. These products kill bacteria, viruses, fungi and mold on hard surfaces. The EPA sets standards for products to make sure that they kill germs and don't pose serious immediate health hazards to people.

All products used to sanitize or disinfect must be registered with the EPA. Only products with EPA registration numbers on the label can claim they kill germs if used as directed. Product labels have information about how to use it to sanitize or disinfect, and which germs are killed.

### What about bleach?

Bleach is the most common product used for sanitizing and disinfecting in Early Care and Education (ECE) programs. If used correctly, bleach reliably sanitizes and disinfects hard, non-porous surfaces of most common and harmful bacteria and viruses. A small amount of bleach can be diluted with water and it is inexpensive.

### Are there problems with bleach?

There are increasing concerns about the health effects of bleach, especially for children and staff with asthma. When bleach is applied to surfaces, fumes get into the air and can irritate the lungs, eyes and the inside of the nose. For staff who mix bleach solutions, contact with full strength bleach can be even more harmful and can damage skin, eyes and clothing.

## SAFER WAYS TO DILUTE BLEACH

- ▶ USE ONLY EPA REGISTERED BLEACH and follow the directions on the label.
- ▶ Select a bottle made of opaque material.
- ▶ Dilute bleach with cool water and *do not use more than the recommended amount of bleach.*
- ▶ Make a fresh bleach solution daily; label the bottle with contents and the date mixed.
- ▶ Wear gloves and eye protection when diluting bleach.
- ▶ Use a funnel.
- ▶ Add bleach to the water rather than water to bleach to reduce fumes.
- ▶ Make sure the room is well ventilated.

**Caution:** Always follow label instructions! Undiluted bleach comes in different concentrations (e.g. 8.25%, 6%, 5.25% sodium hypochlorite). Read the label for exact dilution instructions.

## Are there alternatives to bleach?

Commercial products registered with the EPA as sanitizers or disinfectants may be used according to the directions on the label. Look for an EPA registration number. Follow instructions for dilution (different for sanitizing vs. disinfecting) and contact time. Check if the product is safe for food surfaces, if pre-cleaning is needed, and if rinsing is needed.

Some child care programs are using EPA registered products with hydrogen peroxide, citric acid or lactic acid as the active ingredient because they have fewer irritating fumes. In response to consumer demand, more of these products can be found in stores and online.

Non-chemical equipment, like dishwashers and steam cleaners, can be used to sanitize in certain situations. New methods and technologies like high-quality microfiber cloths and mops used with soap and water can also reduce germs. More studies need to be done to see if these alternative methods work as well as chemicals to sanitize in ECE environments.

Resources and References: American Academy of Pediatrics, American Public Health Association, National Resource Center for Health and Safety in Child Care and Early Education. 2011. *Caring for our children: National health and safety performance standards; Guidelines for early care and education programs. 3rd edition. Appendix J and K*

U.S. Environmental Protection Agency, 2012, *What Are Antimicrobial Pesticides?* [www.epa.gov/oppad001/ad\\_info.htm](http://www.epa.gov/oppad001/ad_info.htm)

## SAFER USE OF BLEACH SOLUTIONS

- ▶ Before applying bleach, clean off dirt and debris with soap or detergent, then rinse with water.
- ▶ If using a spray bottle, apply bleach using a heavy spray instead of a fine mist setting.
- ▶ Keep the surface wet with bleach according to label instructions (use a timer). This is called contact time or dwell time.
- ▶ Sanitize when children are not present.
- ▶ Ventilate the room and allow surfaces to dry completely before allowing children back.
- ▶ Store all chemicals out of reach of children in a way that will not tip or spill.
- ▶ Never mix or store ammonia with bleach or products that contain bleach.

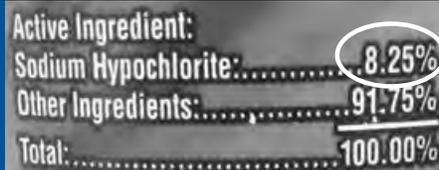
# New Bleach Solutions for 8.25%

REGULAR BLEACH CONCENTRATION IS NOW STRONGER (8.25%)

READ THE LABELS AND TAKE THE FOLLOWING STEPS TO ENSURE SAFETY IN YOUR CHILD CARE FACILITY

**1**

**Identify** what bleach concentration is in your facility. Refer to the chart below for mixing instructions. Find the % sodium hypochlorite on the bottle. Avoid splashless and scented bleaches.



**2**

**Clean**

- Scrub with soap and warm water and rinse.
- Always clean surfaces to remove visible soil, dirt and contamination before using bleach solution.

**3**

**Mix**

- **Mix fresh solutions daily** for sanitizing and disinfecting.
- Mix bleach with cool water.
- Do not mix liquid bleach with other cleaning products, toilet bowl cleaners or ammonia, which may release hazardous gases into the air.

**4**

**Sanitize, Disinfect, Special Clean-up**

- Wet entire surface
- Leave solution on surface for two minutes
- Dry with paper towel or air-dry

Sanitize (100 PPM)	Disinfect (600 PPM)	Special Clean-up (5000 PPM)
<b>CLEAN AND SANITIZE AFTER EACH USE:</b> <ul style="list-style-type: none"> <li>• Children’s mouthed toys</li> <li>• Food service areas, dishes</li> </ul>	<b>CLEAN AND DISINFECT AFTER EACH USE:</b> <ul style="list-style-type: none"> <li>• Diaper changing surface</li> </ul>	<b>CLEAN AND USE AS NEEDED FOR VOMIT AND DIARRHEA:</b> <ul style="list-style-type: none"> <li>• Not for other bodily fluids</li> </ul>
<b>SANITIZE DAILY OR WHEN SOILED:</b> <ul style="list-style-type: none"> <li>• Dishcloths, synthetic sponges</li> <li>• Common surfaces (other than in bathrooms), floors, mats, tables, countertops and hard surfaces, door knobs, etc.</li> </ul>	<b>DISINFECT DAILY OR WHEN SOILED:</b> <ul style="list-style-type: none"> <li>• Bathroom areas</li> </ul>	<b>MIX SOLUTION WHEN NEEDED</b> <b>WEAR GLOVES AND MASKS TO PROTECT YOURSELF</b>
<b>1/8 teaspoon bleach/ pint water</b>	<b>3/4 teaspoon bleach/ pint water</b>	<b>2 tablespoon bleach/ pint water</b>
<b>1/4 teaspoon bleach/ quart water</b>	<b>1 1/2 teaspoon bleach/ quart water</b>	<b>4 tablespoon bleach/ quart water</b>
<b>1 teaspoon bleach/ gallon water</b>	<b>2 tablespoons bleach/ gallon water</b>	<b>1 cup (8 oz) bleach/ gallon water</b>

Visit the Oklahoma State Department of Health’s website to find this and other information for child care providers: [www.health.ok.gov](http://www.health.ok.gov). If you have questions about mixing and using bleach solutions for sanitizing, disinfecting and special clean up, call your local health department’s environmental health specialist or the Oklahoma Department of Human Services, Child Care Services.

This document is also available in Spanish.

For more information, call the OSDH Acute Disease Service at 405-271-4060 or visit <http://ads.health.ok.gov>

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This fact sheet was adapted with permission from the Oregon Health Authority.

# Still Using 5.25-6.00% Bleach? Bleach Solutions for 5.25-6.00%

REGULAR BLEACH CONCENTRATION HAS INCREASED TO **8.25%**.  
IF YOU ARE STILL USING 5.25-6.00%, TAKE THE FOLLOWING STEPS TO ENSURE  
SAFETY IN YOUR CHILD CARE FACILITY

**1**

**Identify** what bleach concentration is in your facility. Refer to the chart below for mixing instructions. Find the % sodium hypochlorite on the bottle. Avoid splashless and scented bleaches.



Active Ingredient:  
Sodium Hypochlorite... 6.00%  
Other Ingredients.....94.00%  
Total.....100.00%

**2**

**Clean**

- Scrub with soap and warm water and rinse.
- Always clean surfaces to remove visible soil, dirt and contamination before using bleach solution.

**3**

**Mix**

- **Mix fresh solutions daily** for sanitizing and disinfecting.
- Mix bleach with cool water.
- Do not mix liquid bleach with other cleaning products, toilet bowl cleaners or ammonia, which may release hazardous gases into the air.

**4**

**Sanitize, Disinfect, Special Clean-up**

- Wet entire surface
- Leave solution on surface for two minutes
- Dry with paper towel or air-dry

Sanitize (100 PPM)	Disinfect (600 PPM)	Special Clean-up (5000 PM)
<b>CLEAN AND SANITIZE AFTER EACH USE:</b> <ul style="list-style-type: none"> <li>• Children’s mouthed toys</li> <li>• Food service areas, dishes</li> </ul>	<b>CLEAN AND DISINFECT AFTER EACH USE:</b> <ul style="list-style-type: none"> <li>• Diaper changing surface</li> </ul>	<b>CLEAN AND USE AS NEEDED FOR VOMIT AND DIARRHEA:</b> <ul style="list-style-type: none"> <li>• Not for other bodily fluids</li> </ul>
<b>SANITIZE DAILY OR WHEN SOILED:</b> <ul style="list-style-type: none"> <li>• Dishcloths, synthetic sponges</li> <li>• Common surfaces (other than in bathrooms), floors, mats, tables, countertops and hard surfaces, door knobs, etc.</li> </ul>	<b>DISINFECT DAILY OR WHEN SOILED:</b> <ul style="list-style-type: none"> <li>• Bathroom areas</li> </ul>	<b>MIX SOLUTION WHEN NEEDED</b>  <b>WEAR GLOVES AND MASKS TO PROTECT YOURSELF</b>
1/8 <b>teaspoon</b> bleach/ <b>pint</b> water	1 1/4 <b>teaspoon</b> bleach/ <b>pint</b> water	<b>3 tablespoon</b> bleach/ <b>pint</b> water
1/4 <b>teaspoon</b> bleach/ <b>quart</b> water	<b>1 tablespoon</b> bleach/ <b>quart</b> water	<b>6 tablespoons</b> bleach/ <b>quart</b> water
<b>1 teaspoon</b> bleach/ <b>gallon</b> water	1/4 <b>cup</b> bleach/ <b>gallon</b> water	<b>1 1/2 cup</b> bleach/ <b>gallon</b> water

Visit the Oklahoma State Department of Health’s website to find this and other information for child care providers: [www.health.ok.gov](http://www.health.ok.gov). If you have questions about mixing and using bleach solutions for sanitizing, disinfecting and special clean up, call your local health department’s environmental health specialist or the Oklahoma Department of Human Services, Child Care Services.

This document is also available in Spanish.

For more information, call the OSDH Acute Disease Service at 405-271-4060 or visit <http://ads.health.ok.gov>

The Oklahoma State Department of Health (OSDH) is an Equal Opportunity Employer.

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Acute Disease Service  
Oklahoma State  
Department of Health

This fact sheet was adapted with permission from the Oregon Health Authority.

# Cover Your Cough The **Right** Way!

Use a tissue and  
trash it  
immediately,  
then wash your  
hands or use  
alcohol - based  
hand gel



OR  
use your  
sleeve: germs  
don't grow or  
spread from  
your clothing



**When you cough  
into your hands,  
you spread germs  
to everything and  
everyone  
you touch**

Additional information at <http://ads.health.ok.gov>



AN EQUAL OPPORTUNITY EMPLOYER  
Designed by Marylee Braun-Wright

These publications were printed and issued by the Oklahoma State Department of Health, and as authorized by James M Crutcher, MD, MPH, Secretary of Health, Commissioner of Health. 8,500 Copies have been printed in June of 2008 at a cost of \$1,275. Copies have been deposited with the Publications Clearinghouse of the Department of Libraries.



## DAILY HEALTH CHECK

**Do the daily health check when you greet each child and parent as they arrive. It usually takes less than a minute. Also observe the child throughout the day.**

**LISTEN:** Greet the child and parent. Ask the child, "How are you today?" Ask the parent, "How are you doing? How's (name of child)?" "Was there anything different last night?" "How did he sleep?" "How was her appetite this morning?"

- Listen to what the child and parent tell you about how the child is feeling.
- If the child can talk, is he complaining of anything? Is he hoarse or wheezing?

**LOOK:** Get down to the child's level to see her clearly. Observe signs of health or illness.

- General appearance (e.g., comfort, mood, behavior, and activity level)
  - Is the child's behavior unusual for this time of day?
  - Is the child clinging to the parent, acting cranky, crying, or fussing?
  - Does she appear listless, in pain, or have difficulty moving?
- Breathing
  - Is the child coughing, breathing fast, or having difficulty breathing?
- Skin
  - Does the child look pale or flushed?
  - Do you see a rash, sores, swelling, or bruising?
  - Is the child scratching her skin or scalp?
- Eyes, Nose, Ears, Mouth
  - Do the child's eyes look red, crusty, goopy, or watery?
  - Is there a runny nose?
  - Is he pulling at his ears?
  - Are there mouth sores, excessive drooling, or difficulty swallowing?

**FEEL:** Gently run the back of your hand over the child's cheek, forehead, or neck.

- Does the child feel unusually warm or cold and clammy?
- Does the skin feel bumpy?

**SMELL:** Be aware of unusual odors.

- Does the child's breath smell foul or fruity?
- Is there an unusual or foul smell to the child's stools?

**Adapted From: *Keeping Kids Healthy*. Sacramento, CA: California Dept. of Education.**



**STOP  
DISEASE**

## DIAPERING PROCEDURES



### 1. Get prepared.

- Gather all diapering supplies so they are within reach, including a diaper, wipes, a plastic bag for soiled clothes, and a plastic-lined, hands-free, covered can.
- Cover the diapering surface with disposable paper.
- Put on disposable gloves.



### 2. Place the child on the diapering table.

- Remove bottom clothes and any soiled clothing.
- Remove socks and shoes that cannot be kept clean.
- Avoid contact with soiled items.
- ALWAYS KEEP ONE HAND ON THE CHILD.



### 3. Unfasten the diaper and clean the child's diaper area.

- With the soiled diaper under the child, lift the child's legs to clean the child's bottom.
- Clean from front to back with a fresh wipe each time.



### 4. Dispose of the diaper and soiled items.

- Put soiled wipes in the soiled diaper.
- Remove the diaper and dispose of it in a plastic-lined, hands-free, covered can.
- If the disposable paper is soiled, use the paper that extends under the child's feet to fold up under the child's bottom.
- Remove gloves and dispose of them in hands-free can.
- Use a fresh wipe to clean your hands.
- Use a fresh wipe to clean the child's hands.



## DIAPERING PROCEDURES



### 5. Put on a clean diaper and dress the child.

- Put a clean diaper under the child.
- Apply diaper cream with a tissue as needed.
- Fasten the diaper, and dress the child.



### 6. Wash the child's hands.

- Moisten hands and apply liquid or foam soap to hand surfaces from finger tips to wrists.
- Rinse with running water.
- Dry with a single use paper or cloth towel.
- Return the child to a supervised area away from the diapering table.



### 7. Clean and disinfect the diaper changing surface.

- Discard the paper liner.
- Remove any visible soil with soap and water.
- Apply EPA-registered disinfectant and use according to label instructions.
- Be sure to leave the disinfectant on the surface for the required contact time.



### 8. Wash your hands with soap and running water, and record the diaper change in a report for parents.

- Include the time of diaper change and diaper contents.
- Note any problems such as skin redness, rashes, or loose stool.

# Keep me home if...



I'm vomiting.



2 or more times in 24 hours.

I have head lice.



AND have not had my first treatment yet.

I have diarrhea.



2 or more watery stools more than usual.

I have an eye infection.



Red eyes with white or yellow mucus AND haven't seen a doctor yet.

I have a sore throat.



With fever or swollen glands.

I'm just not feeling very good.



Unusually tired, pale, lack of appetite, confused cranky or in pain.

I have a rash.



AND fever or mouth sores with drooling.

We have a fever.



AND sore throat, cough, rash, vomiting, diarrhea, pain or just not feeling good.

## WHEN YOUR CHILD IS SICK:

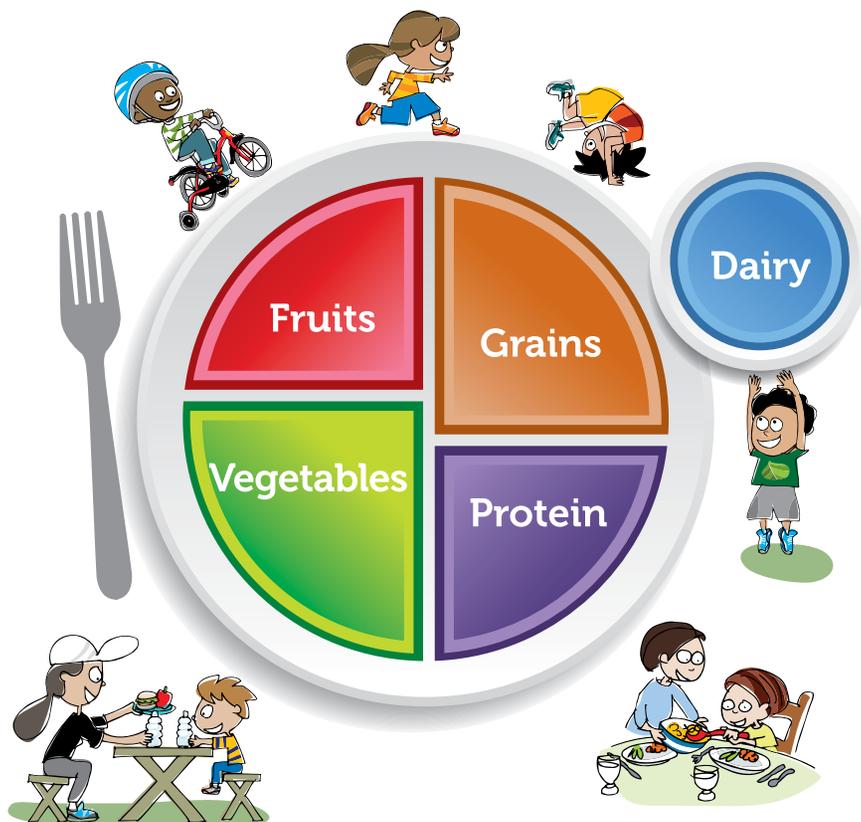
1. HAVE PLANS FOR BACK UP CHILD CARE.
2. TELL YOUR CAREGIVER ABOUT YOUR CHILD'S SIGNS OF ILLNESS, EVEN IF YOUR CHILD STAYS HOME.

Thanks to the Seattle-King County Department of Public Health and The California Childcare Health Program for this information.





# Healthy Eating <sup>for</sup> preschoolers



Choose **MyPlate.gov**

**Get your child on the path to healthy eating.**



*Focus on the meal and each other.*

Your child learns by watching you. Children are likely to copy your table manners, your likes and dislikes, and your willingness to try new foods.

*Offer a variety of healthy foods.*

Let your child choose how much to eat. Children are more likely to enjoy a food when eating it is their own choice.

*Be patient with your child.*

Sometimes new foods take time. Give children a taste at first and be patient with them. Offer new foods many times.

*Let your children serve themselves.*

Teach your children to take small amounts at first. Let them know they can get more if they are still hungry.

*Cook together.*

*Eat together.*

*Talk together.*

*Make meal time family time.*



# Healthy Eating for preschoolers

# Daily Food Plan



Use this Plan as a general guide.

- These food plans are based on average needs. Do not be concerned if your child does not eat the exact amounts suggested. Your child may need more or less than average. For example, food needs increase during growth spurts.
- Children's appetites vary from day to day. Some days they may eat less than these amounts; other days they may want more. Offer these amounts and let your child decide how much to eat.

Food group	2 year olds	3 year olds	4 and 5 year olds	What counts as:
<b>Fruits</b> 	1 cup	1 - 1½ cups	1 - 1½ cups	<b>½ cup of fruit?</b> ½ cup mashed, sliced, or chopped fruit ½ cup 100% fruit juice ½ medium banana 4-5 large strawberries
<b>Vegetables</b> 	1 cup	1½ cups	1½ - 2 cups	<b>½ cup of veggies?</b> ½ cup mashed, sliced, or chopped vegetables 1 cup raw leafy greens ½ cup vegetable juice 1 small ear of corn
<b>Grains</b> Make half your grains whole 	3 ounces	4 - 5 ounces	4 - 5 ounces	<b>1 ounce of grains?</b> 1 slice bread 1 cup ready-to-eat cereal flakes ½ cup cooked rice or pasta 1 tortilla (6" across)
<b>Protein Foods</b> 	2 ounces	3 - 4 ounces	3 - 5 ounces	<b>1 ounce of protein foods?</b> 1 ounce cooked meat, poultry, or seafood 1 egg 1 Tablespoon peanut butter ¼ cup cooked beans or peas (kidney, pinto, lentils)
<b>Dairy</b> Choose low-fat or fat-free 	2 cups	2 cups	2½ cups	<b>½ cup of dairy?</b> ½ cup milk 4 ounces yogurt ¾ ounce cheese 1 string cheese

Some foods are easy for your child to choke on while eating. Skip hard, small, whole foods, such as popcorn, nuts, seeds, and hard candy. Cut up foods such as hot dogs, grapes, and raw carrots into pieces smaller than the size of your child's throat—about the size of a nickel.

There are many ways to divide the Daily Food Plan into meals and snacks. View the "Meal and Snack Patterns and Ideas" to see how these amounts might look on your preschooler's plate at [www.choosemyplate.gov/preschoolers.html](http://www.choosemyplate.gov/preschoolers.html).



## Fact Sheets for Families

# Never Shake a Baby!

Each year, more than 1,300 American children are forcefully shaken by their caretakers. Powerful or violent acts of shaking may lead to serious brain damage—a condition called “shaken baby syndrome” (SBS). The American Academy of Pediatrics, an organization of 55,000 pediatricians, pediatric medical sub-specialists and pediatric surgical specialists, considers shaken baby syndrome to be a clear and serious form of child abuse. Shaken baby syndrome often involves children younger than 2 years but may be seen in children up to 5 years of age.

### What is shaken baby syndrome?

The term “shaken baby syndrome” is used for the internal head injuries a baby or young child sustains from being violently shaken. Babies and young children have very weak neck muscles to control their heavy heads. If shaken, their heads wobble rapidly back and forth, which can result in the brain being bruised from banging against the skull wall.

Generally, shaking happens when someone gets frustrated with a baby or small child. Usually the shaker is fed up with constant crying. However, many adults enjoy tossing children in the air, mistaking the child’s excitement and anxious response for pleasure. Tossing children, even gently, may be harmful and can cause major health problems later on in life.

### What are the signs and symptoms?

Signs of shaken baby syndrome may vary from mild and nonspecific to severe. Although there may be no obvious external signs of injury following shaking, the child may suffer internal injuries. Shaking can cause brain damage, partial or total blindness, deafness, learning problems, retardation, cerebral palsy, seizures, speech difficulties and even death.

Damage from shaking may not be noticeable for years. It

could show up when the child goes to school and is not able to keep up with classmates.

### Tips for prevention

Shaken baby syndrome is completely preventable.

- Never shake a baby—not in anger, impatience, play, or for any reason.
- Avoid tossing small children into the air.

### Address the causes of crying to reduce stress

Caregivers and parents can become exhausted and angry when a baby cries incessantly. Some babies cry a lot when they are hungry, wet, tired or just want company. Some infants cry at certain times. Feeding and changing them may help, but sometimes even that does not work.

If a young child in your care cries a lot, try the following:

- Make sure all of the baby’s basic needs are met.
- Feed the baby slowly and burp the baby often.
- Offer the baby a pacifier, if supplied by parents.
- Hold the baby against your chest and walk or rock him/her.
- Sing to the baby or play soft music.
- Take the baby for a ride in a stroller or car.
- Be patient. If you find you cannot calmly care for the baby or have trouble controlling your anger, take a break. Ask someone else to take care of the baby or put him/her in a safe place to cry it out.
- If the crying continues, the child should be seen by a health care provider.

No matter how impatient or angry you feel, never shake a baby!

### References

National Center on Shaken Baby Syndrome.

American Academy of Pediatrics, *Policy Statement: Pediatrics* Volume 108, Number 1, July 2001, pp. 206-210.

California Childcare Health Program, *Health and Safety in the Child Care Setting: Prevention of Injuries*.

by Rahman Zamani, MD, MPH



Provided by California Childcare Health Program  
For more information, please contact:  
Healthline 1-800-333-3212

Distributed by:



# REPORTABLE DISEASES/ CONDITIONS

The following diseases are to be reported to the OSDH by PHIDDO or telephone (405-271-4060) immediately upon suspicion, diagnosis, or positive test.

Anthrax	Measles (Rubeola)	Rabies
Bioterrorism - suspected disease	Meningococcal invasive disease	Smallpox
Botulism	Novel coronavirus	Tularemia
Diphtheria	Novel influenza A	Typhoid fever
<i>H. influenzae</i> invasive disease	Outbreaks of apparent infectious disease	Viral hemorrhagic fever
Hepatitis A (Anti-HAV-IgM+)	Plague	
Hepatitis B during pregnancy (HBsAg+)	Poliomyelitis	

The following diseases are to be reported to the OSDH by PHIDDO, telephone or secure electronic data transmission within one working day (Monday through Friday, State holidays excepted):

Acid Fast Bacillus (AFB) positive smear (only if no additional testing is performed or subsequent testing is indicative of <i>Mycobacterium tuberculosis</i> Complex)	Listeriosis
AIDS (Acquired Immunodeficiency Syndrome)	Lyme disease
Anaplasmosis	Malaria
Brucellosis	Mump
California serogroup virus	Pertussis
Campylobacteriosis	Powassan virus
Congenital rubella syndrome	Psittacosis
Cryptosporidiosis	Q Fever
Dengue fever	Rocky Mountain spotted fever
Eastern equine encephalitis virus	Rubella
<i>Escherichia coli</i> O157, O157:H7 or a Shiga toxin producing <i>E. coli</i> (STEC)	Salmonellosis
Ehrlichiosis	Shigellosis
Hantavirus pulmonary syndrome	St. Louis encephalitis virus
Hemolytic uremic syndrome, postdiarrheal	<i>Staphylococcus aureus</i> (VISA or VRSA)
Hepatitis B (HBsAg+, anti-HBc IgM+, HBeAg+, and/or HBV DNA+) <sup>1</sup>	<i>Streptococcus pneumoniae</i> invasive disease, children <5 yrs.
Hepatitis C virus (in persons ≤ 40 years or in persons having jaundice or ALT ≥ 400 regardless of age with laboratory confirmation) <sup>1</sup>	Syphilis
Human Immunodeficiency Virus (HIV) infection	Tetanus
Influenza associated hospitalization or death	Trichinellosis
Legionellosis	Tuberculosis
Leptospirosis	Unusual disease or syndrome
	Vibriosis including cholera
	West Nile virus
	Western equine encephalitis virus
	Yellow fever

<sup>1</sup> with entire Hepatitis panel results

The following diseases are to be reported to the OSDH within one month:

CD4 cell count with cell count % (by laboratories only)	Chlamydial infections ( <i>C. trachomatis</i> )	Gonorrhea ( <i>N. gonorrhoeae</i> )
	Creutzfeldt-Jakob disease	HIV viral load (by laboratories only)

Isolates of the following organisms must be sent to the OSDH Public Health Laboratory: P.O. Box 24106 OKC, OK 73214

<i>Bacillus anthracis</i>	<i>Neisseria meningitidis</i> (sterile site isolates)
<i>Brucella</i> spp.	<i>Plasmodium</i> spp.
<i>Escherichia coli</i> O157, O157:H7, or a Shiga toxin producing <i>E. coli</i>	<i>Salmonella</i> spp.
<i>Francisella tularensis</i>	<i>Staphylococcus aureus</i> (VISA or VRSA)
<i>Haemophilus influenzae</i> (sterile site isolates)	<i>Vibrionaceae</i> family ( <i>Vibrio</i> spp., <i>Grimontia</i> spp., <i>Photobacterium</i> spp., and other genera in the family)
<i>Listeria</i> spp. (sterile site isolates)	<i>Yersinia</i> spp.
<i>Mycobacterium tuberculosis</i>	

Acute Disease Service  
(405) 271-4060 or (800) 234-5963  
Available 24 Hours a Day

HIV/STD Service  
(405) 271-4636  
Fax (405) 271-1187

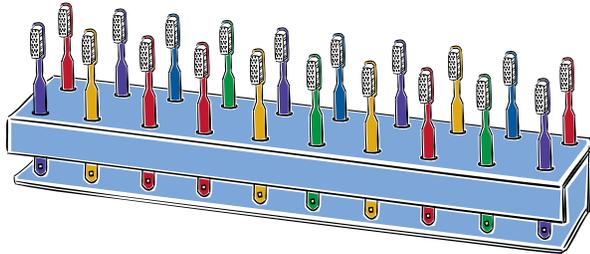
Public Health Laboratory  
(405) 271-5070  
Fax (405) 271-4850

Fax machines are located in locked offices and are monitored to ensure the confidentiality of disease reports.

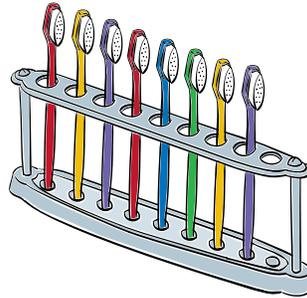
Please refer to the Oklahoma Disease Reporting Manual for reporting guidelines and reportable test results which is available through the Disease Reporting link at <http://ads.health.ok.gov>



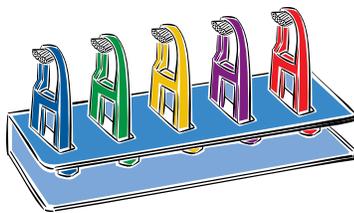
## TOOTHBRUSH STORAGE



Store toothbrushes in open air, so bristles will dry out.



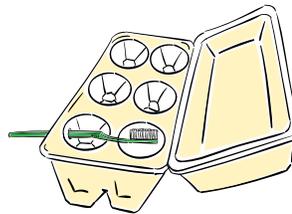
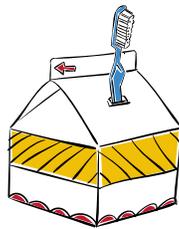
Toothbrushes should be stored vertically, with the bristles on the top.



Space them so that toothbrush bristles do not touch or drip on each other.

Change brushes every 3 months or when worn.

Label toothbrushes and storage rack with children's names.



Use a commercial storage rack or make your own.



## Sexual Development and Behavior in Children



### Information for Parents and Caregivers

*Your five-year-old daughter is playing in her room with a couple of friends. You hear a lot of giggling and squealing.*

*When you open the door to check on the kids, you find them sitting on the floor with their panties off, pointing at and touching each other's genitals.*

#### **What do you do?**

Every day, parents around the world are faced with situations like this. Being caught off-guard by young children's self-exploration and curiosity about body parts and sexual issues is one of the uncomfortable realities of parenting, and can raise a host of troubling questions, such as, "Is my child normal?" "Should I be worried?" "What should I say?"

Although talking with children about bodily changes and sexual matters may feel awkward, providing children with accurate, age-appropriate information is one of the most important things parents can do to make sure children grow up safe, healthy, and secure in their bodies.

### Sexual Development and Behavior in Young Children: The Basics

Like all forms of human development, sexual development begins at birth. Sexual development includes not only the physical changes that occur as children grow, but also the sexual knowledge and beliefs they come to learn and the behaviors they show. Any given child's sexual knowledge and behavior is strongly influenced by:

- The child's age<sup>1-3</sup>
- What the child observes (including the sexual behaviors of family and friends)<sup>4</sup>
- What the child is taught (including cultural and religious beliefs concerning sexuality and physical boundaries)

"Young people do not wake up on their thirteenth birthday, somehow transformed into a sexual being overnight. Even young children are sexual in some form."<sup>5</sup>

**Heather Coleman, PhD & Grant Charles, PhD**  
University of Calgary, Alberta, Canada and  
The University of British Columbia, Vancouver, B.C.

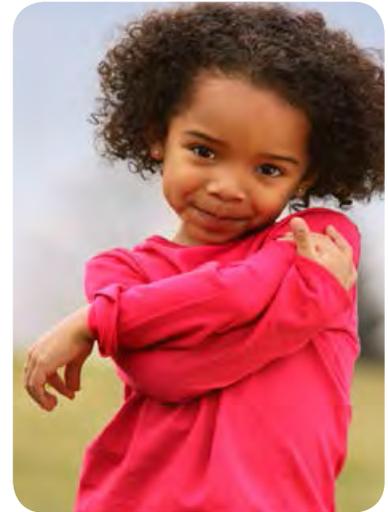
Very young and preschool-aged children (four or younger) are naturally immodest, and may display open—and occasionally startling—curiosity about other people’s bodies and bodily functions, such as touching women’s breasts, or wanting to watch when grownups go to the bathroom. Wanting to be naked (even if others are not) and showing or touching private parts while in public are also common in young children. They are curious about their own bodies and may quickly discover that touching certain body parts feels nice. (For more on what children typically do at this and other ages, see **Table 1.**)

As children age and interact more with other children (approximately ages 4–6), they become more aware of the differences between boys and girls, and more social in their exploration. In addition to exploring their own bodies through touching or rubbing their private parts (masturbation), they may begin “playing doctor” and copying adult behaviors such as kissing and holding hands. As children become increasingly aware of the social rules governing sexual behavior and language (such as the importance of modesty or which words are considered “naughty”), they may try to test these rules by using naughty words. They may also ask more questions about sexual matters, such as where babies come from, and why boys and girls are physically different. (For more, see **Table 1.**)

**Table 1: Common Sexual Behaviors in Childhood<sup>1,3,6</sup>**

<p>Preschool children (less than 4 years)</p>	<ul style="list-style-type: none"> <li>■ Exploring and touching private parts, in public and in private</li> <li>■ Rubbing private parts (with hand or against objects)</li> <li>■ Showing private parts to others</li> <li>■ Trying to touch mother’s or other women’s breasts</li> <li>■ Removing clothes and wanting to be naked</li> <li>■ Attempting to see other people when they are naked or undressing (such as in the bathroom)</li> <li>■ Asking questions about their own—and others’—bodies and bodily functions</li> <li>■ Talking to children their own age about bodily functions such as “poop” and “pee”</li> </ul>
<p>Young Children (approximately 4-6 years)</p>	<ul style="list-style-type: none"> <li>■ Purposefully touching private parts (masturbation), occasionally in the presence of others</li> <li>■ Attempting to see other people when they are naked or undressing</li> <li>■ Mimicking dating behavior (such as kissing, or holding hands)</li> <li>■ Talking about private parts and using “naughty” words, even when they don’t understand the meaning</li> <li>■ Exploring private parts with children their own age (such as “playing doctor”, “I’ll show you mine if you show me yours,” etc.)</li> </ul>
<p>School-Aged Children (approximately 7-12 years)</p>	<ul style="list-style-type: none"> <li>■ Purposefully touching private parts (masturbation), usually in private</li> <li>■ Playing games with children their own age that involve sexual behavior (such as “truth or dare”, “playing family,” or “boyfriend/girlfriend”)</li> <li>■ Attempting to see other people naked or undressing</li> <li>■ Looking at pictures of naked or partially naked people</li> <li>■ Viewing/listening to sexual content in media (television, movies, games, the Internet, music, etc.)</li> <li>■ Wanting more privacy (for example, not wanting to undress in front of other people) and being reluctant to talk to adults about sexual issues</li> <li>■ Beginnings of sexual attraction to/interest in peers</li> </ul>

Once children enter grade school (approximately ages 7–12), their awareness of social rules increases and they become more modest and want more privacy, particularly around adults. Although self touch (masturbation) and sexual play continue, children at this age are likely to hide these activities from adults. Curiosity about adult sexual behavior increases—particularly as puberty approaches—and children may begin to seek out sexual content in television, movies, and printed material. Telling jokes and “dirty” stories is common. Children approaching puberty are likely to start displaying romantic and sexual interest in their peers. (For more, see **Table 1.**)



Although parents often become concerned when a child shows sexual behavior, such as touching another child’s private parts, these behaviors are not uncommon in developing children. Most sexual play is an expression of children’s natural curiosity and should not be a cause for concern or alarm. In general, “typical” childhood sexual play and exploration:

- Occurs between children who play together regularly and know each other well
- Occurs between children of the same general age and physical size
- Is spontaneous and unplanned
- Is infrequent
- Is voluntary (the children agreed to the behavior, none of the involved children seem uncomfortable or upset)
- Is easily diverted when parents tell children to stop and explain privacy rules

Some childhood sexual behaviors indicate more than harmless curiosity, and are considered sexual behavior problems. Sexual behavior problems may pose a risk to the safety and well-being of the child and other children. (For more on this topic, see the National Child Traumatic Stress Network’s factsheet, *Understanding and Coping with Sexual Behavior Problems in Children: Information for Parents and Caregivers* at [http://nctsn.org/nctsn\\_assets/pdfs/caring/sexualbehaviorproblems.pdf](http://nctsn.org/nctsn_assets/pdfs/caring/sexualbehaviorproblems.pdf).) Sexual behavior problems include any act that:

- Is clearly beyond the child’s developmental stage (for example, a three-year-old attempting to kiss an adult’s genitals)
- Involves threats, force, or aggression
- Involves children of widely different ages or abilities (such as a 12-year-old “playing doctor” with a four-year-old)
- Provokes strong emotional reactions in the child—such as anger or anxiety



## Responding to Sexual Behaviors

Situations like the one described at the beginning of this handout can be unsettling for parents. However, these situations also offer excellent opportunities to assess how much children understand and to teach important information about sexual matters.

The first step is to try to **figure out what actually happened**. To do this, it’s important to stay calm. Staying calm will allow you to make clear decisions about what you say and/or do, rather than acting on strong emotions.



To remain composed, try taking a long, deep breath, counting to ten, or even closing the door and stepping away for a couple of minutes before saying anything. In the case described above, a parent might calmly tell the children that it's time to get dressed and then ask each child to go to a different room in the house. After taking a few moments to collect his or her thoughts—and to consult with a spouse or partner if feeling very unsettled—the parent could then talk to each child one-on-one.

When talking to children about sexual behaviors, it's important to [maintain a calm and even tone of voice and to ask open-ended questions](#) as much as possible, so the children can tell what happened in their own words, rather than just answering yes or no. So, in this case, a parent might ask each child:

- What were you doing?
- How did you get the idea?
- How did you learn about this?
- How did you feel about doing it?

In the opening scenario, all of the children involved were about the same age, had been playmates for some time, and seemed to be enjoying their game. So, it's likely the children were just curious and playing around and that no one was upset about what happened. If you encounter a situation where the children are a little embarrassed but otherwise not distressed, this can present an ideal opportunity for teaching the children about healthy boundaries and rules about sexual behavior.

**Myth:** Talking about sex with my children will just encourage them to become sexually active.

**Fact:** In a recent survey of American teens, [9 out of 10 teens said it would be easier to delay sexual activity and prevent unwanted pregnancy if they were able to have “more open, honest conversations” with their parents](#) on these topics.<sup>7</sup> When you talk honestly with your children about sexual issues, you can give them the knowledge and skills they need to keep safe and to make good decisions about relationships and intimacy.

## Educating Children about Sexual Issues

Just because a behavior is typical doesn't mean the behavior should be ignored. Often, when children participate in sexual behavior it indicates that they need to learn something. [Teach what the child needs to know, given the situation](#). In this case, for example, the parent might teach the children that it's okay to be curious about other people's bodies, but that private parts should be kept private, even with friends.

Although children usually respond well when parents take the time to give them correct information and answer their questions, it is important to [provide information that is appropriate to the child's age and developmental level](#). In **Table 2**, you will find an overview of some of the most important information and safety messages for children of various ages. Keep in mind that you do not need to bombard children with information all at once. Let the situation—and the child's questions—guide the lessons you share. The important thing is to let children know that you are ready to listen and to answer whatever questions they may have.

Too often, children get the majority of their sexual education from other children and from media sources such as television shows, songs, movies, and video games. Not only is this information often wrong, it may have very little to do with sexual values that parents want to convey. Explicit adult sexual activities are sometimes found during “family time” television shows, in commercials, and on cartoon/children's channels, and can have an influence on children's behaviors.

Controlling media exposure and providing appropriate alternatives is an important part of teaching children about sexual issues. Get to know the rating systems of games, movies, and television shows and make use of the parental controls available through many internet, cable, and satellite providers.

However, don't assume that just by activating those controls you will be taking care of the situation. It's very important for you to **be aware of what your children are watching on television and online**, and make time to watch television with them. When appropriate, you can use this time as a springboard to talk about sexual or relationship issues, and to help children develop the skills to make healthy decisions about their behavior and relationships.

Table 2: What to Teach When<sup>8</sup>

<b>Preschool children (less than 4 years)</b>	
<p><b>Basic Information</b></p> <ul style="list-style-type: none"> <li>Boys and girls are different</li> <li>Accurate names for body parts of boys and girls</li> <li>Babies come from mommies</li> <li>Rules about personal boundaries (for example, keeping private parts covered, not touching other children's private parts)</li> <li>Give simple answers to all questions about the body and bodily functions.</li> </ul> 	<p><b>Safety Information</b></p> <ul style="list-style-type: none"> <li>The difference between "okay" touches (which are comforting, pleasant, and welcome) and "not okay" touches (which are intrusive, uncomfortable, unwanted, or painful)</li> <li>Your body belongs to you</li> <li>Everyone has the right to say "no" to being touched, even by grownups</li> <li>No one—child or adult—has the right to touch your private parts</li> <li>It's okay to say "no" when grownups ask you to do things that are wrong, such as touching private parts or keeping secrets from mommy or daddy</li> <li>There is a difference between a "surprise"—which is something that will be revealed sometime soon, like a present—and a "secret," which is something you're never supposed to tell. Stress that it is never okay to keep secrets from mommy and daddy</li> <li>Who to tell if people do "not okay" things to you, or ask you to do "not okay" things to them</li> </ul>
<b>Young Children (approximately 4-6 years)</b>	
<p><b>Basic Information</b></p> <ul style="list-style-type: none"> <li>Boys' and girls' bodies change when they get older.</li> <li>Simple explanations of how babies grow in their mothers' wombs and about the birth process.</li> <li>Rules about personal boundaries (such as, keeping private parts covered, not touching other children's private parts)</li> <li>Simple answers to all questions about the body and bodily functions</li> <li>Touching your own private parts can feel nice, but is something done in private</li> </ul>	<p><b>Safety Information</b></p> <ul style="list-style-type: none"> <li>Sexual abuse is when someone touches your private parts or asks you to touch their private parts</li> <li>It is sexual abuse even if it is by someone you know</li> <li>Sexual abuse is NEVER the child's fault</li> <li>If a stranger tries to get you to go with him or her, run and tell a parent, teacher, neighbor, police officer, or other trusted adult</li> <li>Who to tell if people do "not okay" things to you, or ask you to do "not okay" things to them</li> </ul>
<b>School-Aged Children (approximately 7-12 years)</b>	
<p><b>Basic Information</b></p> <ul style="list-style-type: none"> <li>What to expect and how to cope with the changes of puberty (including menstruation and wet dreams)</li> <li>Basics of reproduction, pregnancy, and childbirth</li> <li>Risks of sexual activity (pregnancy, sexually transmitted diseases)</li> <li>Basics of contraception</li> <li>Masturbation is common and not associated with long term problems but should be done in private</li> </ul>	<p><b>Safety Information</b></p> <ul style="list-style-type: none"> <li>Sexual abuse may or may not involve touch</li> <li>How to maintain safety and personal boundaries when chatting or meeting people online</li> <li>How to recognize and avoid risky social situations</li> <li>Dating rules</li> </ul>



If you are unsure of what to say to your child about sexual issues, don't be afraid to do some research. In addition to talking to your pediatrician or doctor, you can turn to online resources such as the Sexuality Information and Education Council of the United States' (SIECUS) *Families Are Talking* websites (listed below). There are also several excellent books available on talking to children about sexual issues, as well as books that you and your children can read together. (For a partial listing, see **Table 3**.)

Table 3: Additional Resources for Communicating with Children About Sexual Issues

<b>For You</b>	
<b>Books</b>	<p>Haffner, Debra W. (2008). <i>From diapers to dating: A parent's guide to raising sexually healthy children— from infancy to middle school, 2nd edition</i>. New York: Newmarket Press.            Author Debra Haffner provides practical advice and guidelines to help you talk to children and early adolescents about sexuality. Includes techniques to identify and examine your own sexual values so that you can share these messages with your children.</p> <p>Hickling, Meg. (2005). <i>The new speaking of sex: What your children need to know and when they need to know it</i>. Kelowna, BC, Canada: Wood Lake Publishing, Inc.            This update of the bestselling <i>More Speaking of Sex</i> is packed with no-nonsense, accurate, and gently funny information on sexuality and sexual health. Author Meg Hickling dispels misconceptions and unhealthy beliefs about sex, provides guidelines on how to talk with children at various stages of their development, and offers examples of how to answer tough questions.</p> <p>Roffman, Deborah M. (2002). <i>But how'd I get in there in the first place? Talking to your young child about sex</i>. New York: Perseus Publishing.            Sexuality and family life educator Deborah Roffman provides clear, sensible guidelines on how to talk confidently with young children about sexual issues, including how to answer sometimes-awkward questions about sexuality, conception, and birth.</p> <p>Roffman, Deborah M. (2001). <i>Sex and sensibility: The thinking parent's guide to talking sense about sex</i>. New York: Perseus Publishing.            This book is designed to inspire honest communication about sexuality between parents and their children. It focuses on the core skills parents need in order to interpret and respond to virtually any question or situation, with the goal of empowering children through knowledge.</p>
<b>Online Resources</b>	<p>The <b>Committee for Children</b> offers tips on how to teach children about safe touch (<a href="http://www.cfchildren.org/issues/abuse/touchsaferules/">http://www.cfchildren.org/issues/abuse/touchsaferules/</a>) as well as general information on how to talk to your child about sexual issues (<a href="http://www.cfchildren.org/issues/abuse/touchsafety/">http://www.cfchildren.org/issues/abuse/touchsafety/</a>).</p> <p>The <b>Sexuality Information and Education Council of the United States' (SIECUS) Families Are Talking</b> websites contain a wealth of information and resources to help you talk with children about sexuality and related issues (<a href="http://www.familiesaretalking.org">http://www.familiesaretalking.org</a> and <a href="http://www.lafamiliahable.org">http://www.lafamiliahable.org</a>).</p>
<b>For Your Children</b>	
<b>Books</b>	<p>Bell, Ruth. (1998). <i>Changing bodies, changing lives: Expanded 3rd edition: A book for teens on sex and relationships</i>. New York: TimesBooks.  <i>For ages 9 and up</i>. Designed to help young people make informed decisions about their lives, <i>Changing bodies, changing lives</i> provides answers to tough questions about how the body works and about sex, love, and relationships. It's packed with illustrations, checklists, and resources, as well as stories, poems, and cartoons from hundreds of teenagers.</p> <p>Brown, Laurie Krasny. (2000). <i>What's the big secret? Talking about sex with girls and boys</i>. New York: Little, Brown Books for Young Readers.  <i>For ages 4–8</i>. This colorful and chatty book uses illustrations, cartoons, and very accessible text to explain the basics of anatomy, reproduction, pregnancy, and birth. Also discusses feelings, touching, and privacy.</p> <p>Hansen, Diane. (2007). <i>Those are MY private parts</i>. Redondo Beach, CA: Empowerment Productions.  <i>For ages 4–8</i>. This short, easy-to-read book uses colorful illustrations and catchy rhymes to teach children that no one—relative, friend or neighbor—has a right to touch them in a way that makes them feel uncomfortable.</p>



## For Your Children (continued)

Harris, Robie H. (2006) *It's NOT the stork: A book about girls, boys, babies, bodies, families and friends*. Somerville, MA: Candlewick Press.

*For ages 4 and up.* This lively, engaging book uses two cartoon characters—a curious bird and a squeamish bee—to give voice to the many emotions and reactions children experience while learning about their bodies. The information provided is up-to-date, age-appropriate, and scientifically accurate, and is designed to help kids feel proud, knowledgeable, and comfortable about their bodies and how they were born.

Harris, Robie H. (2004) *It's perfectly normal: Changing bodies, growing up, sex, and sexual health*. Somerville, MA: Candlewick Press.

*For ages 10 and up.* Providing accurate, unbiased answers to nearly every imaginable question, from conception and puberty to birth control and AIDS, *It's perfectly normal* provides young people with the information they need to make responsible decisions and to stay healthy.

Harris, Robie H. (2004) *It's so amazing!: A book about eggs, sperm, birth, babies, and families*. Somerville, MA: Candlewick Press.

*For ages 4 and up.* *It's so amazing!* provides answers to children's questions about reproduction, sex, and sexuality. The comic-book style artwork and clear, lively text reflects an elementary-school child's interest in science and how things work. Throughout the book, a curious bird and a squeamish bee help tell the story of how a baby is made—from the moment an egg and sperm join, through pregnancy, to birth. *It's so amazing!* also addresses and provides reassuring, age-appropriate information on love, sex, gender, families, heterosexuality, homosexuality, sexual abuse, and HIV and AIDS, while giving children a healthy understanding of their bodies.

Madaras, Lynda. (2007). *The "What's happening to my body?" book for girls, revised 3rd edition*. New York: Newmarket Press.

Madaras, Lynda. (2007). *The "What's happening to my body?" book for boys, revised 3rd edition*. New York: Newmarket Press.

*For ages 10 and up.* These books—part of the acclaimed "What's Happening To My Body?" book series by the same author—provide sensitive straight talk on children's changing bodies, diet and exercise, romantic and sexual feelings, and puberty in the opposite sex. They also include information on sensitive topics such as eating disorders, sexually transmitted diseases, steroid use, and birth control.

Mayle, Peter. (2000). *"What's happening to me?" An illustrated guide to puberty*. New York: Kensington Publishing.

*For ages 9–12.* For more than 20 years, "What's happening to me?" has been helping young people—and their parents—navigate the "time in between" childhood and adolescence.

Mayle, Peter. (2000). *Where did I come from? The facts of life without any nonsense and with illustrations*. New York: Kensington Publishing.

*For ages 4–8.* Dedicated to "red-faced parents everywhere," *Where did I come from?* covers the basic facts of sexuality from physiology to love-making, orgasm, conception, growth inside the womb, and childbirth. The illustrations are clear and realistic, and the text does an excellent job of explaining things in an age-appropriate way.

Schaefer, Valorie. (1998) *The care & keeping of you: The body book for girls*. Middleton, WI: Pleasant Company Publications.

*For ages 7-12.* This "head -to- toe" guide addresses the variety of changes that occur with puberty, and answers many of the questions girls have, from hair care to healthy eating, bad breath to bras, periods to pimples, and everything in between.

Parents play a pivotal role in helping their children develop healthy attitudes and behaviors towards sexuality. Although talking with your children about sex may feel outside your comfort zone, there are many resources available to help you begin and continue the conversation about sexuality. Providing close supervision, and providing clear, positive messages about modesty, boundaries and privacy are crucial as children move through the stages of childhood. By talking openly with your children about relationships, intimacy, and sexuality, you can foster their healthy growth and development.



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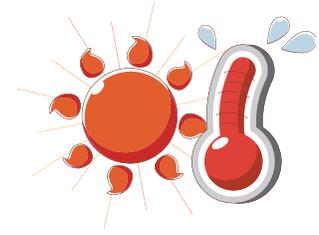
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# Keeping Your Child Safe in the Summer Heat

As your child heads outside to play this summer, remember that children are especially susceptible to the heat. Below are some tips that will help you keep your child safe:



## Keep them hydrated.

Have your child drink a glass of water 1-2 hours before going outside and then another glass 10 to 15 minutes before going out. Once outside, encourage your child to drink about every 20 to 30 minutes, even if he or she isn't thirsty.

## Limit outdoor playtime between 11am and 3pm.

The sun reaches its peak during these hours, so try to plan outdoor activities for earlier or later in the day. If children do play outdoors during these hours, make sure they don't overexert themselves.

## Use sunscreen with SPF 15 or higher to protect children from the sun.

Apply sunscreen to your child 30 minutes before going outside to allow it to absorb into the skin. Reapply every two hours. Remember that sunburns can happen even on cloudy days.

## Dress your child in loose-fitting, lightweight, and light-colored clothing

Clothing made from natural fibers like cotton and linen are best, as these fabrics tend to 'breathe' better than synthetic fabrics like polyester. Tightly woven clothing offers additional sun protection.

## Know the signs and types of heat stress.

Children do not know or understand the symptoms and will play to exhaustion. There are three types of heat stress:

**Heat cramps** - Symptoms include mild fever (under 101°F), painful leg cramps, red face, nausea, and weakness. If cramps occur, have your child stop activity and rest, give him or her plenty of clear fluids (sports drinks, preferably), and move the child to a cool area.

**Heat exhaustion** - Symptoms include lethargy (acting uninterested and/or sluggish); headache; fever up to 102°F; dizziness; heavy sweating; thirst; cool, pale, clammy skin; nausea; vomiting; diarrhea; and anxiety. If you suspect heat exhaustion, take the same steps you would for heat cramps (above), plus give your child a cool bath if possible or wet his or her clothing and call your child's doctor.

**Heat Stroke** - Fever (sometimes above 105°F), confusion, agitation, hysteria, and no sweating. If you suspect a heat stroke, call 911 immediately and take the steps listed above for heat cramps and heat exhaustion.

## NEVER leave a child alone in a car, not even for a minute.

On a 93-degree day, the temperature inside a vehicle can rise to over 125°F in just 20 minutes. To further add to the danger, your child's body heats up 3 to 5 times faster than yours. If your child becomes locked in a vehicle, call 911 immediately.

## Know your local weather forecast.

Pay attention to your local weather forecast and plan activities based on the day's heat index. A heat index of 80°F or below is considered comfortable; 90°F is beginning to feel uncomfortable; 100°F is uncomfortable and hazardous, and 110°F is dangerous.

## Make sure outdoor play equipment and vehicle seats aren't too hot.

Dark car interiors and car seats, metal seatbelt buckles, and metal slides can get especially hot; and children can be burned in just one second.

Sources:

[WBAY-TV](#) | [Children's Healthcare of Atlanta](#) | [Council for Children & Families](#) | [HealthyChildren](#) | [Iowa Dept. of Public Health](#)

PO Box 55930  
Little Rock, AR 72215-5930



1-800-305-7322  
[www.SouthernEarlyChildhood.org](http://www.SouthernEarlyChildhood.org)

## Action Steps for Sun Protection

While some exposure to sunlight can be enjoyable, too much can be dangerous. Overexposure to ultraviolet (UV) radiation from the sun can result in a painful sunburn. It can also lead to more serious health problems, including skin cancer, premature aging of the skin, cataracts and other eye damage, and immune system suppression. Children are particularly at risk. This fact sheet explains simple steps to protect yourself and your children from overexposure to UV radiation.

### Be SunWise

Most people are not aware that skin cancer, while largely preventable, is the most common form of cancer in the United States. More than one million cases are reported annually. By following some simple steps, you can still enjoy your time in the sun and protect yourself from overexposure. The U.S. Environmental Protection Agency (EPA) recommends these action steps to help you and your family be “SunWise.”



#### Do Not Burn

Sunburns significantly increase one's lifetime risk of developing skin cancer, especially for children.



#### Avoid Sun Tanning and Tanning Beds

UV light from tanning beds and the sun causes skin cancer and wrinkling.



#### Generously Apply Sunscreen

Generously apply sunscreen: about one ounce to cover all exposed skin 20 minutes before going outside. Sunscreen should have a Sun Protection Factor (SPF) of at least 15 and provide protection from both ultraviolet A (UVA) and ultraviolet B (UVB) rays. Reapply every two hours, even on cloudy days, and after swimming or sweating.



#### Wear Protective Clothing

Wear protective clothing, such as a long-sleeved shirt, pants, a wide-brimmed hat, and sunglasses, when possible.

 **SunWise®**  
a program that radiates good ideas



### Seek Shade

Seek shade when possible and remember that the sun's UV rays are strongest between 10 a.m. and 4 p.m.



### Use Extra Caution Near Water, Snow and Sand

Water, snow and sand reflect the damaging rays of the sun, which can increase your chance of sunburn.



### Check the UV Index

The UV Index provides important information to help you plan your outdoor activities in ways that prevent sun overexposure. The UV Index forecast is issued daily by the National Weather Service and EPA. Visit [www.epa.gov/sunwise/uvindex.html](http://www.epa.gov/sunwise/uvindex.html).



### Get Vitamin D Safely

Get Vitamin D safely through a diet that includes vitamin supplements and foods fortified with Vitamin D. Don't seek the sun.

Early detection of skin cancer can save your life. A new or changing mole should be evaluated by a dermatologist.

## Special Considerations for Children

Recent medical research shows that it is important to protect children and young adults from overexposure to UV radiation. For babies under 6 months, the American Academy of Pediatrics recommends (1) avoiding sun exposure, and (2) dressing infants in lightweight long pants, long-sleeved shirts, and brimmed hats. Parents can also apply sunscreen (SPF 15+) to small areas like the face and back of the hands if protective clothing and shade are not available.

## EPA's SunWise Program

In response to the serious public health threat posed by overexposure to UV radiation, EPA is working with schools and communities across the nation through the SunWise Program. SunWise is an environmental and health education program that teaches children how to protect themselves from overexposure to the sun.

## UV Index

Exposure Category	UVI Range
Low	< 2
Moderate	3 to 5
High	6 to 7
Very high	8 to 10
Extreme	11+

The UV Index forecasts the strength of the sun's harmful rays. The higher the number, the greater the chance of sun damage.

Visit [www.epa.gov/sunwise/uvindex.html](http://www.epa.gov/sunwise/uvindex.html).

## For More Information

To learn more about UV radiation, the action steps for sun protection, and the SunWise Program, call EPA's Stratospheric Ozone Information Hotline at 800.296.1996, or visit our Web site at [www.epa.gov/sunwise](http://www.epa.gov/sunwise).



## WASH YOUR HANDS PROPERLY



1. Wet hands and apply soap. Use warm running water; liquid soap is best.



2. Rub hands together vigorously, thoroughly scrubbing all surfaces from wrists to fingertips.



3. Rinse hands well under running water until all the soil and soap are gone.



4. Dry hands with a fresh paper towel.



5. Turn off water with your paper towel—not with your clean hands.



6. Discard the used paper towels in a lined, hands-free canister.



# When to Wash Hands



Wash hands at key points during the day.



**1** Before children arrive for the day.



**2** After cleaning.



**3** Upon arrival and after coming inside from outdoor play.



**4** Before and after preparing and eating food.



**5** After diapering or toileting.



**6** After contact with body fluids.



**7** After touching animals or their equipment.

## **Child Care Warmline 1-888-574-5437**

The Warmline for Oklahoma Child Care Providers offers free telephone consultation to child care providers on numerous topics of concern. Consultants can also refer providers to appropriate services and resources within their communities and can help generate ideas and clarify problems.

*My class is out of control. What can I do?  
How can I tell if a child has ringworm?  
A child is biting other children. How can I help?  
I'm worried about a child's development.  
How can I talk to the parents about my concerns?*

Anyone who cares for children needs someone to talk to occasionally about those puzzling questions regarding behavior, child development, health, safety, working with parents and more.

The Child Care Warmline is as close as a telephone and is available to help child care providers find solutions to the daily dilemmas of caring for children.

Trained professionals in child development, guidance, parent education, health and safety are available to assist providers in finding answers to questions and the resources needed to provide quality care for children. Consultants are available Monday through Friday from 8:00 a.m. until 5:00 p.m. Messages left after hours will be answered as soon as a consultant is available.

The automated Warmline Library has pre-recorded messages on a variety of topics related to child care, health, and development and is available 24 hours a day. A list of topics can be accessed at <http://warmline.health.ok.gov/>. **Questions can also be emailed to the Warmline at [warmline@health.ok.gov](mailto:warmline@health.ok.gov).**

The Child Care Warmline is a service provided by Child Guidance Service, Oklahoma State Department of Health, and the Department of Human Services, Child Care Services.

## Child Care Warmline Phone Codes

### Behavior, Development, and Parenting Issues

- 3706 Bedwetting in Children
- 1304 Biting in the Toddler Years
- 1305 Biting: What to do When a Child Bites
- 1306 Biting: Strategies to Prevent Biting in Child Care
- 1308 Children's Fears
- 4313 Disciplining Your Child
- 1301 "Good" Byes: Helping Children Adjust to Child Care
- 4809 Sleep Patterns in Newborns
- 3739 New Baby Creates Jealousy
- 3743 Normal Development 15 to 18 Months Old
- 3744 Normal Development 18 to 24 Months Old
- 3747 Normal Development 2 Years Old
- 3748 Normal Development 3 Years Old
- 3750 Normal Development 4 Years Old
- 3751 Normal Development 5 Years Old
- 3223 Pigeon Toe
- 4344 Self-Esteem: Your Child's Self-Esteem
- 4329 Separation Anxiety Prevention
- 3801 Sexual Behaviors in Children
- 4333 Sibling Relationships
- 1310 Sleep & Children: How Much is Enough?
- 3766 Sleep Disorders in Children
- 3764 Sleep Patterns in Children
- 3344 Sleep: Nightmares & Night Terrors
- 3769 Speech Development in Newborns to 5 Year Olds
- 1307 Tantrums
- 3775 Temper Tantrums
- 3777 Thumb-Sucking
- 3779 Toddler Discipline
- 1302 Toddler Practicing Independence in Child Care
- 1303 Toilet Learning
- 3780 Toilet Training

### Behavior continued: Infant Behavior and Development

- 3715 Crying Baby
- 3722 New Father
- 3736 New Mother
- 3746 Normal Development 2 Weeks to 2 Months
- 3745 Normal Development 2-4 Months
- 3749 Normal Development 4-6 Months
- 3752 Normal Development 6-9 Months

- 3753 Normal Development 9-12 Months
- 3765 Sleep Apnea in Babies
- 3765 Sleep Patterns in Babies
- 3771 Sudden Infant Death Syndrome or SIDS
- 3774 Teething

### **Care & Safety**

- 3113 Allergic Reaction (Severe) or Anaphylaxis
- 4900 Bites: Animal & Human
- 3105 Bites: Bites & Stings
- 4943 Bites: Tick
- 4851 Blisters
- 4909 Choking
- 4906 CPR or Cardiopulmonary Resuscitation
- 4934 Cuts, Scrapes & Scratches
- 3852 Dental Care for Children
- 4656 Drowning Prevention in Children
- 3107 Drug Allergy
- 4912 Electric Shock
- 4206 Eyes: Scratch on the Surface of the Eye or Corneal Abrasions
- 4915 First Aid for Superficial or First-Degree Burns
- 3109 Food Allergy
- 4918 Food Poisoning
- 4922 Frostbite
- 3413 Head Trauma
- 4728 Healthy Diet
- 4737 Healthy Snacks for Children
- 1314 Heat Exhaustion or Heat Stroke
- 3192 Hip Dislocation in Childhood
- 4925 Home First Aid Supplies
- 4663 Immunization Schedule for Children
- 4945 Insect Repellent Use
- 4129 Exercise for Kids
- 4270 Medications: Nonprescription
- 3735 Medications: Safety in Children
- 4669 Preventing Burns & Scalds
- 3271 RICE: Rest, Ice, Compression, Elevation
- 4674 Safety Seats for Children
- 4940 Splinters
- 3245 Sprains
- 4871 Sunburn

## Common Childhood Health Issues & Infectious Diseases

- 3100 Allergies
- 4402 Anemia
- 4801 Asthma
- 4545 Chicken Pox
- 4506 Common Cold
- 3714 Croup
- 3950 Ear Infection or Otitis Media
- 3108 Eczema or Atopic Dermatitis
- 4508 Fifth Disease
- 4522 Flu or Influenza
- 4513 Group A Strep Invasive Diseases
- 4514 Hand-Foot-and-Mouth Disease
- 3110 Hay Fever or Seasonal Allergic Rhinitis
- 4024 Hepatitis A
- 4025 Hepatitis B
- 4026 Hepatitis C
- 4516 HIV Infection & AIDS
- 4860 Impetigo
- 4524 Lice
- 4525 Lyme Disease
- 4550 Measles
- 3705 Meningitis: Bacterial Meningitis in Children
- 3785 Meningitis: Viral Meningitis in Children
- 4551 Mumps
- 4218 Pinkeye
- 4811 Pneumonia
- 3106 Rashes: Contact Dermatitis
- 3718 Rashes: Diaper
- 3112 Rashes: Poison Ivy, Oak, and Sumac
- 3794 Respiratory Syncytial Virus (RSV)
- 4528 Ringworm
- 4530 Rubella or German Measles
- 4509 Salmonellosis
- 4531 Scabies
- 4534 Shingles or Herpes Zoster
- 3770 Spitting Up in Infants
- 3960 Strep Throat
- 4538 Tetanus
- 3858 Thrush
- 4540 Tuberculosis or TB
- 3713 Viral Infections in Children
- 4873 Warts
- 4542 West Nile Virus
- 3787 Whooping Cough or Pertussis

## **Help for Families**

- 1313 Child Care Consultation for Facilities Experiencing Challenging Behaviors in the Classroom
- 1319 Oklahoma Child Care Resource & Referral Agency: Help Finding Child Care
- 1312 What is Infant Mental Health?
- 1311 Where to Go When You have a Concern about the Development of a Child: What is SoonerStart and How do I Refer a Family?

## **Mental Health Concerns**

- 3302 Aggressive Behavior in Children
- 3788 Anger & Teaching Children to Manage It
- 3310 Anxiety
- 3370 Bullying: How to Help the Victim
- 3369 Bullying: When Your Child is a Bully
- 3300 Child Abuse & Neglect
- 3772 Depression in Children & Teens
- 3321 Depression Overview
- 3326 Emotional Abuse: Effects on Children
- 3330 Grief & Loss
- 3350 Post-Traumatic Stress Disorder (PTSD)
- 3360 Sexual Abuse & Children
- 4425 Stress
- 4426 Stress Management
- 4427 Stress Management with Deep Breathing

## **Special Health Care Needs**

- 3312 ADHD or Attention Deficit-Hyperactivity Disorder in Children
- 4822 Asthma & How to Use Inhalers
- 3701 Asthma in Children
- 3704 Autistic Spectrum Disorder (ASD)
- 3711 Childhood Cancers
- 4203 Common Vision Problems
- 4207 Crossed or Misaligned Eyes or Strabismus
- 3905 Diabetes: Type 1
- 3782 Diabetes: Type 1 in Children
- 3906 Diabetes: Type 2
- 4314 Down Syndrome
- 3109 Food Allergy
- 3727 Hearing Loss in Children
- 4721 Overweight Children
- 3767 Speech & Language Problems

## Symptoms of Illness

- 5050 Abdominal Pain
- 3406 Concussion
- 4008 Constipation
- 4809 Cough
- 4910 Dehydration
- 4010 Diarrhea
- 5054 Dizziness & Vertigo
- 3963 Ears: Earache
- 3953 Ears: Earwax
- 3957 Ears: Ruptured Eardrum
- 5072 Ears: Tinnitus (Ringing in the Ears)
- 5056 Fatigue
- 5057 Fever
- 3418 Headaches: Migraine
- 3427 Headaches: Sinus
- 3629 Heart Palpitations
- 4021 Heartburn
- 4029 Indigestion
- 5060 Insomnia
- 5065 Nausea and Vomiting
- 3956 Nosebleed or Epistaxis
- 5071 Swallowing Difficulty or Dysphagia

## County Health Departments

<b>County</b>	<b>City</b>	<b>Telephone</b>
Adair	Stilwell	(918) 696-7292
Atoka	Atoka	(580) 889-2116
Beaver	Beaver	(580) 625-3693
Beckham	Elk City	(580) 225-1173
Beckham	Sayre	(580) 928-5551
Blaine	Watonga	(580) 623-7977
Bryan	Durant	(580) 924-4285
Caddo	Anadarko	(405) 247-2507
Canadian	El Reno	(405) 262-0042
Canadian	Yukon	(405) 354-4872
Carter	Ardmore	(580) 223-9705
Carter	Healdton	(580) 229-1291
Cherokee	Tahlequah	(918) 456-8826
Choctaw	Hugo	(580) 326-8821
Cleveland	Moore	(405) 794-1591
Cleveland	Norman	(405) 321-4048
Coal	Coalgate	(580) 927-2367
Comanche	Lawton	(580) 248-5890
Cotton	Walters	(580) 875-6121
Craig	Vinita	(918) 256-7531
Creek	Bristow	(918) 367-3341
Creek	Drumright	(918) 352-9581
Creek	Sapulpa	(918) 224-5531
Custer	Clinton	(580) 323-2100
Custer	Weatherford	(580) 772-6417
Delaware	Jay	(918) 253-4511
Garfield	Enid	(580) 233-0650

<b>County</b>	<b>City</b>	<b>Telephone</b>
Garvin	Lindsay	(405) 756-2928
Garvin	Paul's Valley	(405) 238-7346
Grady	Chickasha	(405) 224-2022
Grant	Medford	(580) 395-2906
Greer	Mangum	(580) 782-5531
Harmon	Hollis	(580) 688-3348
Harper	Buffalo	(580) 735-6100
Harper	Laverne	(580) 921-2029
Haskell	Stigler	(918) 967-3304
Hughes	Holdenville	(405) 379-3313
Jackson	Altus	(580) 482-7308
Jefferson	Waurika	(580) 228-2313
Johnston	Tishomingo	(580) 371-2470
Kay	Blackwell	(580) 363-5520
Kay	Ponca City	(580) 762-1641
Kingfisher	Kingfisher	(405) 375-3008
Kiowa	Hobart	(580) 726-3316
Latimer	Wilburton	(918) 465-5673
LeFlore	Poteau	(918) 647-8601
Lincoln	Chandler	(405) 258-2640
Logan	Guthrie	(405) 282-3485
Love	Marietta	(580) 276-2531
McClain	Blanchard	(405) 485-3319
McClain	Purcell	(405) 527-6541
McCurtain	Idabel	(580) 286-6628
McIntosh	Checotah	(918) 473-5416
McIntosh	Eufaula	(918) 689-7774
Major	Fairview	(580) 227-3362

<b>County</b>	<b>City</b>	<b>Telephone</b>
Marshall	Madill	(580) 795-3705
Mayes	Pryor	(918) 825-4224
Murray	Sulphur	(580) 622-3716
Muskogee	Muskogee	(918) 683-0321
Noble	Perry	(580) 336-2257
Okfuskee	Okemah	(918) 623-1800
Oklahoma City-County	Oklahoma City	(405) 427-8651
Okmulgee	Beggs	(918) 267-3606
Okmulgee	Henryetta	(918) 652-8250
Okmulgee	Okmulgee	(918) 756-1883
Osage	Pawhuska	(918) 287-3740
Ottawa	Miami	(918) 540-2481
Pawnee	Cleveland	(918) 358-2546
Pawnee	Pawnee	(918) 762-3643
Payne	Cushing	(918) 225-3377
Payne	Stillwater	(405) 372-8200
Pittsburg	McAlester	(918) 423-1267
Pontotoc	Ada	(580) 332-2011
Pottawatomie	Shawnee	(405) 273-2157
Pushmataha	Antlers	(580) 298-6624
Pushmataha	Clayton	(918) 569-7973
Rogers	Claremore	(918) 341-3166
Seminole	Seminole	(405) 382-4369
Seminole	Wewoka	(405) 257-5401
Sequoyah	Sallisaw	(918) 775-6201
Stephens	Duncan	(580) 252-0270
Texas	Guymon	(580) 338-8544
Tillman	Frederick	(580) 335-2163
Tulsa City-County	Tulsa	(918) 582-9355

<b>County</b>	<b>City</b>	<b>Telephone</b>
Wagoner	Coweta	(918) 486-2845
Wagoner	Wagoner	(918) 485-3022
Washington	Bartlesville	(918) 335-3005
Washita	Clinton	(580) 323-2100
Woods	Alva	(580) 327-3192
Woodward	Woodward	(580) 256-6416

## **Developmental and Behavioral Resources for Children**

### **Birth to 5: Watch Me Thrive!**

<http://www.acf.hhs.gov/programs/ecd/child-health-development/watch-me-thrive>

*Birth to 5: Watch Me Thrive!* is a coordinated federal effort to encourage healthy child development, universal developmental and behavioral screening for children, and support for the families and providers who care for them. This initiative draws heavily on previous developmental and behavioral screening efforts by consolidating materials from a wide array of federal agencies and their non-federal partners. They have published a list of research-based developmental screening tools appropriate for use across a wide range of settings

### **The Survey of Wellbeing of Young Children**

<http://www.theswyc.org>

The Survey of Wellbeing of Young Children (SWYC) is a freely-available, comprehensive screening instrument for children under 5 years of age. The SWYC was written to be simple to answer, short, and easy to read. The entire instrument requires 15 minutes or less to complete and is straightforward to score and interpret.

### **Watch Me! Celebrating Milestones and Sharing Concerns**

<http://www.cdc.gov/ncbddd/watchmetraining/index.html>

This FREE, online training course, offered through the Center for Disease Control and Prevention (CDC) *Watch Me! Celebrating Milestones and Sharing Concerns*, helps early childhood professionals by providing tools and best practices for monitoring the development of children in care and talking about it with their parents.

## Health and Safety Resources for Children

**California Childcare Health Program** produces quality materials on health and safety in early care and education settings for professionals and families.

- <http://www.ucsfchildcarehealth.org/html/pandr/pandrmain.htm>

### Center for Disease Control and Prevention (CDC)

- Developmental Milestones <http://www.cdc.gov/ncbddd/actearly/milestones/index.html>
- Safety in the Home and Community <http://www.cdc.gov/parents/children/safety.html>

### Consumer Product Safety Commission (CPSC)

- Current Safety News & Infant Crib Safety <http://www.cpsc.gov/>
- Recalled products <http://www.cpsc.gov/en/Recalls/>
- Safety education <http://www.cpsc.gov/en/Safety-Education/>

**Healthy Child Care America (HCCA)** The HCCA Child Care & Health Partnership is a collaborative effort of health professionals and child care providers working to improve the early education and health and safety of children in out-of-home child care. This includes increasing access to preventive health services, safe physical environments, and a medical home for all children. The program also strives to increase pediatrician participation and effectiveness in providing high-quality care and promoting early education and children's health and well-being. <http://healthychildcare.org>

**HealthyChildren.org**, from the American Academy of Pediatrics (AAP), is the only parenting website backed by 64,000 pediatricians committed to the optimal physical, mental, and social health and well-being for all infants, children and adolescents. <http://www.healthychildren.org>

**Let's Move!** – an initiative launched by the First Lady, dedicated to solving the challenge of childhood obesity. *Let's Move!* is about putting children on the path to a healthy future during their earliest months and years. Giving parents and providers helpful information and fostering environments that support healthy choices. <http://www.letsmove.gov/>

Sign up to participate in **Let's Move! Child Care**: <http://healthykidshealthyfuture.org/> and receive ideas and resources to use in your program.

### National Resource Center for Health and Safety in Child Care and Early Education (NRC)

- The NRC website has information for caregivers and teachers, parents, regulators, child care health consultants, and home visitors: <http://nrckids.org/>
- *Caring for Our Children, National Health and Safety Performance Standards* (CFOC) <http://cfoc.nrckids.org/>
- Healthy Weight Resources <http://nrckids.org/index.cfm/products/healthy-weight-resources/>

### **The Oklahoma Caring Van Program**

The Oklahoma Caring Van Program is designed to eliminate barriers that commonly prevent children from receiving on-time, age-appropriate immunizations. The Caring Vans travel to licensed child care programs, schools, and community locations statewide.

<http://www.oklahomacaringfoundation.org/>

### **The Oklahoma Center for Poison & Drug Information: 1(800) 222-1222**

The Oklahoma Center for Poison & Drug Information (OCPDI) provides information about the prevention and management of potential toxic exposures. The OCPDI is a free, confidential resource that is open 24 hours a day, 7 days a week, 365 days a year, and is staffed by pharmacists, doctors and nurses who are nationally certified as Specialists in Poison Information.

<http://www.oklahomapoison.org/>

**The Oklahoma State Department of Health** has many helpful resources for working with children, including the online version of the *Good Health Handbook*. <http://www.ok.gov/health>

Be sure to look at the information in the following areas:

Acute Disease Service created a Resources for Schools and Child Care Settings web page:

[http://www.ok.gov/health/Disease\\_Prevention\\_Preparedness/Acute\\_Disease\\_Service/Disease\\_Information/School\\_and\\_Childcare\\_Setting\\_Resources/](http://www.ok.gov/health/Disease_Prevention_Preparedness/Acute_Disease_Service/Disease_Information/School_and_Childcare_Setting_Resources/)

Certified Healthy Oklahoma Programs

Child Guidance Service

Immunization Service

Injury Prevention Service

Maternal and Child Health Service

Preparing for a Lifetime, It's Everyone's Responsibility

**The Period of Purple Crying** is a program for parents of newborns to understand why babies cry, and what they can do. Read more about it at: <http://purplecrying.info/>.

**Safe Kids Worldwide** is a global organization dedicated to protecting kids from unintentional injuries through research, education and awareness programs, and public policy.

<http://safekids.org/>

**Safe Kids Oklahoma** provides dedicated and caring staff, operation support, and other resources to assist in achieving the goal of keeping kids safe. They can be reached at (405)945-6709.

**Safe to Sleep<sup>®</sup> Public Action Campaign:** the Safe to Sleep<sup>®</sup> campaign, formerly known as the Back to Sleep campaign, focuses on actions you and others can take to help your baby sleep safely and to reduce your baby's risk of Sudden Infant Death Syndrome (SIDS) and other sleep-related causes of infant death. <http://www.nichd.nih.gov/sts/>

**SoonerCare** (Oklahoma Medicaid) is a health coverage program jointly funded by the federal and state government. This program helps pay some or all medical bills for many people who can't afford them. The Oklahoma Health Care Authority (OHCA) is the state agency that administers the program and determines financial eligibility for the program.

<http://www.okhca.org/>

**SoonerStart** is Oklahoma’s early intervention program. It is designed to meet the needs of families with infants or toddlers with developmental delays. In accordance with the Individuals with Disabilities Education Act (IDEA) the program builds upon and provides supports and resources to assist family members to enhance their infant’s or toddler’s learning and development through everyday learning opportunities.

[http://www.ok.gov/health/Child\\_and\\_Family\\_Health/SoonerStart/](http://www.ok.gov/health/Child_and_Family_Health/SoonerStart/)

**Stop Bullying** – a website to help you understand bullying, the many types, who is at risk, how to respond, and prevention efforts. <http://www.stopbullying.gov/>

**Text4Baby** – Text4baby is a free cell phone text messaging service for pregnant women and new moms. Text messages are sent three times a week with information on how to have a healthy pregnancy and a healthy baby. The text messages are timed to the pregnant woman’s due date or the baby’s date of birth, and continue through the baby’s first year of life. The free text messages provide tips on subjects including breastfeeding, car seat safety, developmental milestones, emotional well-being, exercise and fitness, immunizations, nutrition, and safe sleep. Share this information with parents: Text **BABY** to **511411** to sign up for English text4baby messages, or **BEBE** at **511411** for Spanish text messages.

**United States Department of Agriculture (USDA) Food and Nutrition Service:** a resource for the **Child and Adult Care Food Program (CACFP)** guidelines and resources for healthy meals and menu planning. <http://www.fns.usda.gov/cacfp/child-and-adult-care-food-program>

**ZERO TO THREE** is a national, nonprofit organization that provides parents, professionals, and policymakers the knowledge and know-how to nurture early development. <http://www.zerotothree.org/>

## Anaphylaxis Emergency Action Plan

Patient Name: \_\_\_\_\_ Age: \_\_\_\_\_

Allergies: \_\_\_\_\_

Asthma  Yes (*high risk for severe reaction*)  No

Additional health problems besides anaphylaxis: \_\_\_\_\_

Concurrent medications: \_\_\_\_\_

	<b>Symptoms of Anaphylaxis</b>
<b>MOUTH</b>	itching, swelling of lips and/or tongue
<b>THROAT*</b>	itching, tightness/closure, hoarseness
<b>SKIN</b>	itching, hives, redness, swelling
<b>GUT</b>	vomiting, diarrhea, cramps
<b>LUNG*</b>	shortness of breath, cough, wheeze
<b>HEART*</b>	weak pulse, dizziness, passing out

*Only a few symptoms may be present. Severity of symptoms can change quickly.  
\*Some symptoms can be life-threatening. ACT FAST!*

### Emergency Action Steps - DO NOT HESITATE TO GIVE EPINEPHRINE!

1. Inject epinephrine in thigh using (check one):
- |   |   |
|---|---|
| <input type="checkbox"/> Adrenaclick (0.15 mg)                      | <input type="checkbox"/> Adrenaclick (0.3 mg) |
| <input type="checkbox"/> Auvi-Q (0.15 mg)                           | <input type="checkbox"/> Auvi-Q (0.3 mg)      |
| <input type="checkbox"/> EpiPen Jr (0.15 mg)                        | <input type="checkbox"/> EpiPen (0.3 mg)      |
| <b>Epinephrine Injection, USP Auto-injector- authorized generic</b> |   |
| <input type="checkbox"/> (0.15 mg)                                  | <input type="checkbox"/> (0.3 mg)             |
| <input type="checkbox"/> Other (0.15 mg)                            | <input type="checkbox"/> Other (0.3 mg)       |

Specify others: \_\_\_\_\_

**IMPORTANT: ASTHMA INHALERS AND/OR ANTIHISTAMINES CAN'T BE DEPENDED ON IN ANAPHYLAXIS.**

2. Call 911 or rescue squad (before calling contact)

3. Emergency contact #1: home \_\_\_\_\_ work \_\_\_\_\_ cell \_\_\_\_\_

Emergency contact #2: home \_\_\_\_\_ work \_\_\_\_\_ cell \_\_\_\_\_

Emergency contact #3: home \_\_\_\_\_ work \_\_\_\_\_ cell \_\_\_\_\_

Comments: \_\_\_\_\_

\_\_\_\_\_  
Doctor's Signature/Date/Phone Number

\_\_\_\_\_  
Parent's Signature (for individuals under age 18 yrs)/Date



Name: \_\_\_\_\_ D.O.B.: \_\_\_\_\_

Allergy to: \_\_\_\_\_

Weight: \_\_\_\_\_ lbs. Asthma: [ ] **Yes (higher risk for a severe reaction)** [ ] **No**

**PLACE  
PICTURE  
HERE**

**NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.**

**Extremely reactive to the following foods:** \_\_\_\_\_

THEREFORE:

[ ] If checked, give epinephrine immediately for ANY symptoms if the allergen was likely eaten.

[ ] If checked, give epinephrine immediately if the allergen was definitely eaten, even if no symptoms are noted.

## FOR ANY OF THE FOLLOWING: SEVERE SYMPTOMS



### LUNG

Short of breath, wheezing, repetitive cough



### HEART

Pale, blue, faint, weak pulse, dizzy



### MOUTH

Significant swelling of the tongue and/or lips

### THROAT

Tight, hoarse, trouble breathing/swallowing



### SKIN

Many hives over body, widespread redness



### GUT

Repetitive vomiting, severe diarrhea



### OTHER

Feeling something bad is about to happen, anxiety, confusion

**OR A COMBINATION** of symptoms from different body areas.



### 1. INJECT EPINEPHRINE IMMEDIATELY.

2. **Call 911.** Tell them the child is having anaphylaxis and may need epinephrine when they arrive.

- Consider giving additional medications following epinephrine:
  - » Antihistamine
  - » Inhaler (bronchodilator) if wheezing
- Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
- If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
- Alert emergency contacts.
- Transport them to ER even if symptoms resolve. Person should remain in ER for at least 4 hours because symptoms may return.

## MILD SYMPTOMS



### NOSE

Itchy/runny nose, sneezing



### MOUTH

Itchy mouth



### SKIN

A few hives, mild itch



### GUT

Mild nausea/discomfort

**FOR MILD SYMPTOMS FROM MORE THAN ONE SYSTEM AREA, GIVE EPINEPHRINE.**

**FOR MILD SYMPTOMS FROM A SINGLE SYSTEM AREA, FOLLOW THE DIRECTIONS BELOW:**

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

## MEDICATIONS/DOSES

Epinephrine Brand: \_\_\_\_\_

Epinephrine Dose: [ ] 0.15 mg IM [ ] 0.3 mg IM

Antihistamine Brand or Generic: \_\_\_\_\_

Antihistamine Dose: \_\_\_\_\_

Other (e.g., inhaler-bronchodilator if wheezing): \_\_\_\_\_

PARENT/GUARDIAN AUTHORIZATION SIGNATURE

DATE

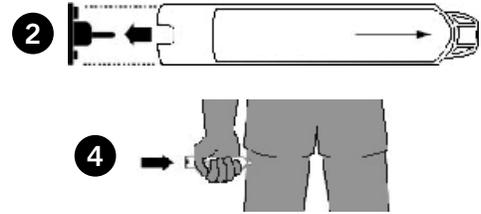
PHYSICIAN/HCP AUTHORIZATION SIGNATURE

DATE



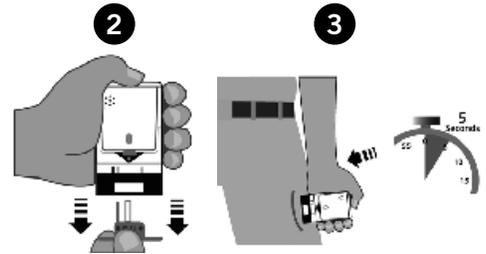
**EPIPEN® (EPINEPHRINE) AUTO-INJECTOR DIRECTIONS**

1. Remove the EpiPen Auto-Injector from the plastic carrying case.
2. Pull off the blue safety release cap.
3. Swing and firmly push orange tip against mid-outer thigh.
4. Hold for approximately 10 seconds.
5. Remove and massage the area for 10 seconds.



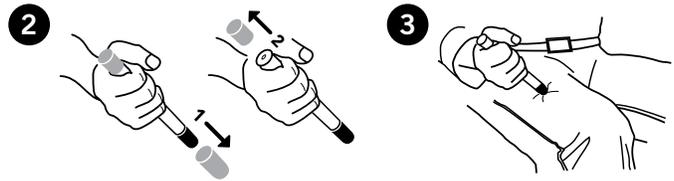
**AUVI-Q™ (EPINEPHRINE INJECTION, USP) DIRECTIONS**

1. Remove the outer case of Auvi-Q. This will automatically activate the voice instructions.
2. Pull off red safety guard.
3. Place black end against mid-outer thigh.
4. Press firmly and hold for 5 seconds.
5. Remove from thigh.



**ADRENACLICK®/ADRENACLICK® GENERIC DIRECTIONS**

1. Remove the outer case.
2. Remove grey caps labeled "1" and "2".
3. Place red rounded tip against mid-outer thigh.
4. Press down hard until needle penetrates.
5. Hold for 10 seconds. Remove from thigh.



**OTHER DIRECTIONS/INFORMATION** (may self-carry epinephrine, may self-administer epinephrine, etc.):

Treat the person before calling emergency contacts. The first signs of a reaction can be mild, but symptoms can get worse quickly.

**EMERGENCY CONTACTS — CALL 911**

RESCUE SQUAD: \_\_\_\_\_

DOCTOR: \_\_\_\_\_ PHONE: \_\_\_\_\_

PARENT/GUARDIAN: \_\_\_\_\_ PHONE: \_\_\_\_\_

**OTHER EMERGENCY CONTACTS**

NAME/RELATIONSHIP: \_\_\_\_\_

PHONE: \_\_\_\_\_

NAME/RELATIONSHIP: \_\_\_\_\_

PHONE: \_\_\_\_\_

PARENT/GUARDIAN AUTHORIZATION SIGNATURE

DATE

# SAMPLE ASTHMA ACTION PLAN

## Asthma Action Plan, for Children 0–5 Years

Name \_\_\_\_\_

DOB \_\_\_\_\_

Record # \_\_\_\_\_

Health Care Provider's Name \_\_\_\_\_

Health Care Provider's Phone Number \_\_\_\_\_ Completed by \_\_\_\_\_ Date \_\_\_\_\_

Long-Term Control Medicines (Use every day to stay healthy)	How Much To Take	How Often	Other Instructions (such as spacers/masks, nebulizers)
		____ times per day EVERY DAY	
		____ times per day EVERY DAY	
		____ times per day EVERY DAY	

Quick-Relief Medicines	How Much To Take	How Often	Other Instructions
		Give <b>ONLY</b> as needed	NOTE: If this medicine is needed often (____ per week), call physician

GREEN ZONE	<p><b>Child is WELL and has no asthma symptoms, even during active play</b></p>	<p><b>Prevent</b> asthma symptoms every day</p> <ul style="list-style-type: none"> <li>• <b>Give the above long-term control medicines every day</b></li> <li>• Avoid things that make the child's asthma worse</li> <li><input checked="" type="checkbox"/> Avoid tobacco smoke, ask people to smoke outside</li> <li><input type="checkbox"/> _____</li> <li><input type="checkbox"/> _____</li> </ul>
YELLOW ZONE	<p><b>Child is NOT WELL and has asthma symptoms that may include:</b></p> <ul style="list-style-type: none"> <li>• Coughing</li> <li>• Wheezing</li> <li>• Runny nose or other cold symptoms</li> <li>• Breathing harder or faster</li> <li>• Awakening due to coughing or difficulty breathing</li> <li>• Playing less than usual</li> <li>• _____</li> <li>• _____</li> </ul> <p>Other symptoms that could indicate that your child is having trouble breathing may include: difficulty feeding (grunting sounds, poor sucking), changes in sleep patterns, cranky and tired, decreased appetite</p>	<p><b>CAUTION:</b> Take action by continuing to give regular asthma medicines <b>every day AND:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Give _____ _____ (include dose and frequency)</li> </ul> <p>If the Child is not in the <i>Green Zone</i> and still has symptoms after 1 hour:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Give _____ _____ (include dose and frequency)</li> <li><input type="checkbox"/> Give _____ _____ (include dose and frequency)</li> <li><input type="checkbox"/> Call _____</li> </ul>
RED ZONE	<p><b>Child FEELS AWFUL warning signs may include:</b></p> <ul style="list-style-type: none"> <li>• Child's wheeze, cough or difficult breathing continues or worsens, even after giving yellow zone medicines</li> <li>• Child's breathing is so hard that he/she is having trouble walking/talking/eating/playing</li> <li>• Child is drowsy or less alert than normal</li> </ul> <p><b>DANGER!</b></p> <p><b>Get help immediately! Call 9-1-1 if:</b></p>	<p><b>MEDICAL ALERT! Get help!</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Take the child to the hospital or call 9-1-1 immediately!</li> <li><input type="checkbox"/> Give more _____ _____ (include dose and frequency) until you get help</li> <li><input type="checkbox"/> Give more _____ _____ (include dose and frequency) until you get help</li> </ul> <ul style="list-style-type: none"> <li>• <b>The child's skin is sucked in around neck and ribs or</b></li> <li>• <b>Lips and/or fingernails are grey or blue, or</b></li> <li>• <b>Child doesn't respond to you.</b></li> </ul>

Source: <http://www.calasthma.org/uploads/resources/actionplanpdf.pdf>. San Francisco Bay Area Regional Asthma Management Plan.  
<http://www.rampasthma.org>

Source: National Heart, Lung, and Blood Institute National Asthma Education and Prevention. *Expert Panel Report 3; Guidelines for the Diagnosis and Management of Asthma; Full Report 2007*. Bethesda, MD: NHLBI; 2007:118.

## Asthma Action Plan, for Children 0–5 Years, *continued*

### PROVIDER INSTRUCTIONS FOR ASTHMA ACTION PLAN (Children ages 0-5)

- Determine the Level of Asthma severity** (see Table 1)
- Fill In Medications**  
Fill in medications appropriate to that level (see Table 1) and include instructions, such as “shake well before using” “use with spacer”, and “rinse mouth after using”.
- Address Issues Related To Asthma Severity**  
These can include allergens, smoke, rhinitis, sinusitis, gastro-esophageal reflux, sulfite sensitivity, medication interactions, and viral respiratory infections.
- Fill in and Review Action Steps**  
Complete the recommendations for action in the different zones, and review the whole plan with the family so they are clear on how to adjust the medications, and when to call for help.
- Distribute copies of the plan**  
Give the top copy of the plan to the family, the next one to school, day care, caretaker, or other involved third party as appropriate, and file the last copy in the chart.
- Review Action plan Regularly (Step Up/Step Down Therapy)**  
A patient who is always in the green zone for some months may be a candidate to “step down” and be reclassified to a lower level of asthma severity and treatment. A patient frequently in the yellow or red zone should be assessed to make sure inhaler technique is correct, adherence is good, environmental factors are not interfering with treatment, and alternative diagnoses have been considered. If these considerations are met, the patient should “step up” to a higher classification of asthma severity and treatment. Be sure to fill out a new asthma action plan when changes in treatment are made.

**TABLE 1 SEVERITY AND MEDICATION CHART** (Classification is based on meeting at least one criterion)

	<b>Severe Persistent</b>	<b>Moderate Persistent</b>	<b>Mild Persistent</b>	<b>Mild Intermittent</b>
<b>Symptoms/Day</b>	Consistent symptoms	Daily symptoms	> 2 days/week but < 1 time/day	≤ 2 days/week
<b>Symptoms/Night</b>	Frequent	> 1 night/week	> 2 nights/month	≤ 2 nights/month
<b>Long Term Control<sup>1</sup></b>	<p><b>Preferred treatment:</b></p> <ul style="list-style-type: none"> <li>• Daily <i>high-dose</i> inhaled corticosteroid</li> </ul> <p><b>AND</b></p> <ul style="list-style-type: none"> <li>• Log acting inhaled B<sub>2</sub> – agonist</li> </ul> <p><b>AND, if needed:</b></p> <ul style="list-style-type: none"> <li>• Corticosteroid tablets or syrup long term (2 mg/kg/day, generally do not exceed 60 mg per day). (Make repeated attempts to reduce systemic corticosteroids and maintain control with high-dose inhaled corticosteroids.)</li> </ul> <p><b>Consultation With Asthma Specialist Recommended</b></p>	<p><b>Preferred treatment:</b></p> <ul style="list-style-type: none"> <li>• Daily <i>low dose</i> inhaled corticosteroid and long-acting inhaled B<sub>2</sub> – agonist</li> <li>OR</li> <li>• Daily <i>medium-dose</i> inhaled corticosteroid</li> </ul> <p><b>Alternative treatment:</b></p> <ul style="list-style-type: none"> <li>• Daily <i>low-dose</i> inhaled corticosteroid and either leukotriene receptor antagonist or theophylline</li> </ul> <p>.....</p> <p><b>If needed</b> (particularly in patients with recurring severe exacerbations):</p> <p><b>Preferred treatment:</b></p> <ul style="list-style-type: none"> <li>• Daily <i>medium dose</i> inhaled corticosteroid and long-acting inhaled B<sub>2</sub> – agonist</li> </ul> <p><b>Alternative treatment:</b></p> <ul style="list-style-type: none"> <li>• Daily <i>medium-dose</i> inhaled corticosteroid and either leukotriene receptor antagonist or theophylline</li> </ul> <p><b>Consultation With Asthma Specialist Recommended</b></p>	<p><b>Preferred treatment:</b></p> <ul style="list-style-type: none"> <li>• Daily <i>low dose</i> inhaled corticosteroid (with nebulizer or MDI with holding chamber with or without face mask or DPI)</li> </ul> <p><b>Alternative treatment:</b></p> <ul style="list-style-type: none"> <li>• Cromolyn (nebulizer is preferred or MDI with holding chamber)</li> <li>OR</li> <li>• Leukotriene receptor antagonist</li> </ul> <p><b>Note:</b> Initiation of long-term controller therapy should be considered if child has had more than three episodes of wheezing in the past year that lasted more than one day and affected sleep and who have risk factors for the development of asthma<sup>2</sup></p> <p><b>Consultation With Asthma Specialist Recommended</b></p>	<b>NO</b> daily medication needed.
<b>Quick Relief<sup>1</sup></b>	<p><b>Preferred treatment:</b></p> <ul style="list-style-type: none"> <li>• Inhaled short-acting B<sub>2</sub> – Agonist</li> </ul> <p><b>Alternative treatment:</b></p> <ul style="list-style-type: none"> <li>• Oral B<sub>2</sub> – agonist</li> </ul>	<p><b>Preferred treatment:</b></p> <ul style="list-style-type: none"> <li>• Inhaled short-acting B<sub>2</sub> – Agonist</li> </ul> <p><b>Alternative treatment:</b></p> <ul style="list-style-type: none"> <li>• Oral B<sub>2</sub> – agonist</li> </ul>	<p><b>Preferred treatment:</b></p> <ul style="list-style-type: none"> <li>• Inhaled short-acting B<sub>2</sub> – Agonist</li> </ul> <p><b>Alternative treatment:</b></p> <ul style="list-style-type: none"> <li>• Oral B<sub>2</sub> – agonist</li> </ul>	<p><b>Preferred treatment:</b></p> <ul style="list-style-type: none"> <li>• Inhaled short-acting B<sub>2</sub> – Agonist</li> </ul> <p><b>Alternative treatment:</b></p> <ul style="list-style-type: none"> <li>• Oral B<sub>2</sub> – agonist</li> </ul>

<sup>1</sup> For infants and children use spacer or spacer AND MASK.

<sup>2</sup> Risk factors for the development of asthma are parental history of asthma, physician-diagnosed eczema or two of the following: physician-diagnosed allergic rhinitis, wheezing apart from colds, peripheral blood eosinophilia. With viral respiratory infection, use bronchodilator every 4-6 hours up to 24 hours (longer with physician consult); in general no more than once every six weeks. If patient has seasonal asthma on a predictable basis, long-term anti-inflammatory therapy (inhaled corticosteroids, cromolyn) should be initiated prior to the anticipated onset of symptoms and continued through the season.

This Asthma Plan was developed by a committee facilitated by the Childhood Asthma Initiative, a program funded by the California Children and Families Commission, and the Regional Asthma Management and Prevention (RAMP) Initiative, a program of the Public Health Institute. This plan is based on the recommendations from the National Heart, Lung, and Blood Institute’s. “Guidelines for the Diagnosis and Management of Asthma.” NIH Publication No. 97-4051 (April 1997) and “Update on Selected Topics 2002.” NIH Publication No. 02-5075 (June 2002). The information contained herein is intended for the use and convenience of physicians and other medical personnel, and may not be appropriate for use in all circumstances. Decisions to adopt any particular recommendation must be made by qualified medical personnel in light of available resources and the circumstances presented by individual patients. No entity or individual involved in the funding or development of this plan makes any warranty guarantee, express or implied, of the quality, fitness, performance or results of use of the information or products described in the plan or the Guidelines. For additional information, please contact RAMP at (510) 622-4438, <http://www.rampasthma.org>.

# Asthma Action Plan, for Children 6 Years or Older

Name \_\_\_\_\_

DOB \_\_\_\_\_

Record # \_\_\_\_\_

Health Care Provider's Name \_\_\_\_\_

Health Care Provider's Phone Number \_\_\_\_\_ Completed by \_\_\_\_\_ Date \_\_\_\_\_

Long-Term Control Medicines (Use every day to stay healthy)	How Much To Take	How Often	Other Instructions (such as spacers/masks, nebulizers)
		_____ times per day EVERY DAY	
		_____ times per day EVERY DAY	
		_____ times per day EVERY DAY	
		_____ times per day EVERY DAY	

Quick-Relief Medicines	How Much To Take	How Often	Other Instructions
		Take <b>ONLY</b> as needed	NOTE: If this medicine is needed frequently, call physician to consider increasing long-term-control medications

Special instructions when I feel **good** (green), **not good** (yellow), and **awful** (red).

**GREEN ZONE**

I feel **good**.  
(My **peak flow** is in the **GREEN** zone.)

---

**YELLOW ZONE**

I do **not** feel **good**.  
(My **peak flow** is in the **YELLOW** zone.)  
My symptoms may include one or more of the following:

- Wheeze
- Tight chest
- Cough
- Shortness of breath
- Waking up at night with asthma symptoms
- Decreased ability to do usual activities
- \_\_\_\_\_
- \_\_\_\_\_

---

**RED ZONE**

I feel **awful**.  
(My **peak flow** is in the **RED** zone.)  
Warning signs may include one or more of the following:

- It's getting harder and harder to breathe.
- Unable to sleep or do usual activities because of trouble breathing.

**DANGER!**  
**Get help immediately!**

**GREEN**  
Peak Flow  
My Personal Best

-----

**YELLOW**  
80% Personal Best

-----

**RED**  
50% Personal Best

-----

Liters/Min.  
**Peak Flow Meter**

**Prevent** asthma symptoms everyday

- Take my long-term-control medicines (above) every day
- Before exercise, take \_\_\_\_\_ puffs of \_\_\_\_\_
- Avoid things that make my asthma worse like: \_\_\_\_\_

---

**CAUTION:** I should continue taking my long-term-control asthma medicines every day AND:

- Take \_\_\_\_\_

If I do not feel good, or my peak flow is not in the *Green Zone* within 1 hour, then I should:

- Increase \_\_\_\_\_
- Add \_\_\_\_\_
- Call \_\_\_\_\_

---

**MEDICAL ALERT! Get help!**

- Take \_\_\_\_\_ until I get help immediately!
- Take \_\_\_\_\_
- Call \_\_\_\_\_

Call 9-1-1 if you have trouble walking or talking due to shortness of breath or lips or fingernails are gray or blue.

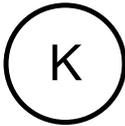
Source: Adapted and reprinted with permission from the Regional Asthma Management and Prevention (RAMP) initiative, a program of the Public Health Institute. <http://www.calasthma.org/uploads/resources/actionplanpdf.pdf>. San Francisco Bay Area Regional Asthma Management Plan.  
 Source: <http://www.calasthma.org/uploads/resources/actionplanpdf.pdf>. San Francisco Bay Area Regional Asthma Management Plan. <http://www.rampasthma.org>  
 Source: National Heart, Lung, and Blood Institute National Asthma Education and Prevention. *Expert Panel Report 3; Guidelines for the Diagnosis and Management of Asthma; Full Report 2007*. Bethesda, MD: NHLBI; 2007:117.

Doctor \_\_\_\_\_ Doctor's Phone Number \_\_\_\_\_ .Date \_\_\_\_\_

Hospital/Emergency Department Phone Number \_\_\_\_\_

GREEN ZONE	<p><b>Doing Well</b></p> <ul style="list-style-type: none"> <li>No cough, wheeze, chest tightness, or shortness of breath during the day or night</li> <li>Can do usual activities</li> </ul> <p><b>And, if a peak flow meter is used,</b></p> <p><b>Peak flow:</b> more than _____ (80 percent or more of my best peak flow)</p> <p>My best peak flow is: _____</p>	<p>Take these long-term-control medicines each day (include an anti-inflammatory).</p> <table border="0"> <thead> <tr> <th style="text-align: left;">Medicine</th> <th style="text-align: left;">How much to take</th> <th style="text-align: left;">When to take it</th> </tr> </thead> <tbody> <tr> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> </tr> </tbody> </table> <p>Identify and avoid and control the things that make your asthma worse, like (list here):</p> <p>_____</p> <p>_____</p> <p>Before exercise, if prescribed, take: <input type="checkbox"/> 2 or <input type="checkbox"/> 4 puffs _____ 5 to 60 minutes before exercise</p>	Medicine	How much to take	When to take it	_____	_____	_____	_____	_____	_____
Medicine	How much to take	When to take it									
_____	_____	_____									
_____	_____	_____									
YELLOW ZONE	<p><b>ASTHMA IS GETTING WORSE.</b></p> <ul style="list-style-type: none"> <li>Cough, wheeze, chest tightness or shortness of breath, or</li> <li>Waking at night due to asthma or</li> <li>Can do some but not all usual activities</li> </ul> <p><b>-OR-</b></p> <p><b>Peak Flow:</b> _____ to _____ (50 to 79 percent of my best peak flow)</p>	<p><b>1 Add quick-relief medicine — and keep taking your GREEN ZONE medicine.</b></p> <p>_____ <input type="checkbox"/> 2 or <input type="checkbox"/> 4 puffs every 20 minutes for up to 1 hour (short acting B<sub>2</sub> agonist) <input type="checkbox"/> Nebulizer, once</p> <p><b>If applicable remove yourself from the thing that made your asthma worse</b></p> <hr/> <p><b>2 If your symptoms (and peak flow, if used) return to GREEN ZONE after 1 hour of above treatment:</b></p> <p><input type="checkbox"/> Continue monitoring to be sure you stay in the green zone</p> <p><b>-OR-</b></p> <p><b>If your symptoms (and peak flow, if used) do NOT return to GREEN ZONE after 1 hour of above treatment:</b></p> <p><input type="checkbox"/> Take _____ <input type="checkbox"/> 2 or <input type="checkbox"/> 4 puffs or <input type="checkbox"/> Nebulizer (short acting B<sub>2</sub> agonist)</p> <p><input type="checkbox"/> Add _____ mg per day. For _____ (3-10) days (oral corticosteroid)</p> <p><input type="checkbox"/> Call the doctor _____ <input type="checkbox"/> before <input type="checkbox"/> within _____ hours after taking the oral corticosteroid (phone)</p>									
RED ZONE	<p><b>MEDICAL ALERT</b></p> <ul style="list-style-type: none"> <li>Very short of breath, or</li> <li>Quick relief medicines have not helped, or</li> <li>Cannot do usual activities, or</li> <li>Symptoms are same or get worse after 24 hours in Yellow Zone</li> </ul> <p><b>-OR-</b></p> <p><b>Peak Flow:</b> less than _____ (50 percent of my best peak flow)</p>	<p><b>Take this medication:</b></p> <p><input type="checkbox"/> _____ <input type="checkbox"/> 4 or <input type="checkbox"/> 6 puffs or <input type="checkbox"/> Nebulizer (short acting B<sub>2</sub> agonist)</p> <p><input type="checkbox"/> _____ mg. (oral corticosteroid)</p> <p><b>Then call your doctor NOW.</b> Go to the hospital or call an ambulance if:</p> <ul style="list-style-type: none"> <li>You are still in the RED ZONE after 15 minutes AND</li> <li>You have not reached your doctor</li> </ul>									
<p><b>Danger Signs</b></p> <ul style="list-style-type: none"> <li>Trouble walking and talking due to shortness of breath</li> <li>Lips or fingernails are blue</li> </ul> <p style="text-align: right;"> <input type="checkbox"/> Take <input type="checkbox"/> 4 or <input type="checkbox"/> 6 puffs of your quick-relief medication AND  <input type="checkbox"/> Go to the hospital or call for an ambulance _____ NOW                  (phone)             </p>											

Source: National Heart, Lung, and Blood Institute. National Institutes of Health, U.S. Department of Health and Human Services. NIH Publication No 07-5251, October 2006.  
 Source: National Heart, Lung, and Blood Institute National Asthma Education and Prevention. *Expert Panel Report 3; Guidelines for the Diagnosis and Management of Asthma; Full Report 2007.* Bethesda, MD: NHLBI; 2007:119.



Areas	Before Each Use	After Each Use	Daily (At the End of the Day)	Weekly	Monthly	Comments
<b>Food Areas</b>						
• Food preparation surfaces	Clean, Sanitize	Clean, Sanitize				Use a sanitizer safe for food contact
• Eating utensils & dishes		Clean, Sanitize				If washing the dishes and utensils by hand, use a sanitizer safe for food contact as the final step in the process; Use of an automated dishwasher will sanitize
• Tables & highchair trays	Clean, Sanitize	Clean, Sanitize				
• Countertops		Clean	Clean, Sanitize			Use a sanitizer safe for food contact
• Food preparation appliances		Clean	Clean, Sanitize			
• Mixed use tables	Clean, Sanitize					Before serving food
• Refrigerator					Clean	
<b>Child Care Areas</b>						
• Plastic mouthed toys		Clean	Clean, Sanitize			
• Pacifiers		Clean	Clean, Sanitize			Reserve for use by only one child; Use dishwasher or boil for one minute
• Hats			Clean			Clean after each use if head lice present
• Door & cabinet handles			Clean, Disinfect			

• Floors			Clean			Sweep or vacuum, then damp mop, (consider micro fiber damp mop to pick up most particles)
• Machine washable cloth toys				Clean		Launder
• Dress-up clothes				Clean		Launder
• Play activity centers				Clean		
• Drinking Fountains			Clean, Disinfect			
• Computer keyboards		Clean, Sanitize				Use sanitizing wipes, do not use spray
• Phone receivers			Clean			
<b>Toilet &amp; Diapering Areas</b>						
• Changing tables		Clean, Disinfect				Clean with detergent, rinse, disinfect
• Potty chairs		Clean, Disinfect				
• Handwashing sinks & faucets			Clean, Disinfect			
• Countertops			Clean, Disinfect			
• Toilets			Clean, Disinfect			
• Diaper pails			Clean, Disinfect			
• Floors			Clean, Disinfect			Damp mop with a floor cleaner/ disinfectant
<b>Sleeping Areas</b>						
• Bed sheets & pillow cases				Clean		Clean before use by another child
• Cribs, cots, & mats				Clean		Clean before use by another child
• Blankets					Clean	

### Consent for Release of Information (to the child care program)

I \_\_\_\_\_ give permission for  
FULL NAME OF PARENT/GUARDIAN  
\_\_\_\_\_ to release to  
PROFESSIONAL/FACILITY  
\_\_\_\_\_ the following information  
CHILD CARE PROGRAM  
\_\_\_\_\_ .

The information will be used to plan and coordinate the care of my child and will be kept confidential and may only be shared with \_\_\_\_\_ .

Name of Child: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

\_\_\_\_\_  
PARENT/LEGAL GUARDIAN SIGNATURE DATE

\_\_\_\_\_  
WITNESS SIGNATURE DATE

\_\_\_\_\_  
STAFF MEMBER TO BE CONTACTED FOR ADDITIONAL INFORMATION

# CONSENT FOR RELEASE OF STAFF HEALTH RECORDS

I, \_\_\_\_\_, hereby authorize \_\_\_\_\_  
*full name of staff person* *full name of Child Care Health Consultant*  
to review my health records on file at the child care program: \_\_\_\_\_  
*full name of program*  
Additionally, I authorize communication about these records between \_\_\_\_\_  
*name of Child Care Health Consultant*  
and \_\_\_\_\_ with the understanding that my consent for review of  
*full name of the Director of the child care program*  
my health records/information and authorization of communication shall be for the limited purpose of understand-  
ing and addressing my health needs as they pertain to maintaining and improving child care staff health at  
\_\_\_\_\_. Further, \_\_\_\_\_ is authorized  
*name of child care program* *name of Child Care Health Consultant*  
to share the information gained with his/her supervisor(s) and/or child care health consulting staff working directly  
with her/him.

I understand that information regarding my health found in my health record file is generally confidential and may  
*not* be given to employees of other schools, public agencies or individual professionals in private practice without  
my consent or other legal requirement.

This consent is given voluntarily and I understand that I can withdraw my consent at any time. Unless I withdraw  
consent, this authorization will be effective for the period of my employment at \_\_\_\_\_.  
*name of child care program*

By signing below I am confirming that I have read, understood and agree to the above conditions and services.

**Staff Name:** \_\_\_\_\_  
*print full name*

**Staff Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

*American Academy of Pediatrics and American Public Health Association, (2002). Caring for our children: National health and safety standards: Guidelines for out-of-home child care programs, Second Edition. Elk Grove Village, IL.*

NOTE: In accordance with the Health Insurance Portability and Accountability Act (HIPPA) and applicable California laws,  
all personal and health information is private and must be protected.

# Child Care Diabetes Medical Management Plan



YOUR RIGHTS. ONE VOICE™

Name of Child: \_\_\_\_\_ DOB: \_\_\_\_\_ Dates Plan in Effect: \_\_\_\_\_  
 Parent or guardian Name(s)/Number(s): \_\_\_\_\_  
 Diabetes Care Provider Name/Number: \_\_\_\_\_  
 Diabetes Care Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Location of diabetes supplies at child care facility: \_\_\_\_\_

## Blood Glucose Monitoring

Target range for blood glucose is:  80-180  Other \_\_\_\_\_  
 When to check blood glucose:  before breakfast  before lunch  before dinner  before snacks  
 When to do extra blood glucose checks:  before exercise  after exercise  when showing signs of low blood glucose  
 when showing signs of high blood glucose  other \_\_\_\_\_

**Insulin Plan:** Please indicate which type of insulin regimen this child uses (check one):

Insulin Pump  Multiple Daily Injections  Fixed Insulin Doses

Specific information related to each insulin regimen/plan is included below for this child.

Type of insulin used at child care (check all that apply):  Regular  Apidra  Humalog  Novolog  NPH  
 Lantus  Levemir  Mix  Other \_\_\_\_\_

### Plan A: Insulin Pump\*

- Always use the insulin pump bolus wizard:  Yes  No  
 If no, use Insulin:Carbohydrate Ratio and Correction Factor dosage on Plan B.
- Blood glucose must be checked before the child eats and will (check one):  
 Be sent to the pump by the meter  
 Need to be entered into the pump
- The insulin pump will calculate the correction dose to be delivered **before** the meal/snack.
- After the meal/snack**, enter the total number of carbohydrates eaten at that meal/snack. The insulin pump will calculate the insulin dose for the meal.
- Contact parent/guardian with any concerns.

For a list of definitions of terms used in this document, please see the *Diabetes Dictionary*.

**\*Providers should complete Insulin:Carbohydrate ratio and Correction dosage under Plan B section for ALL pump users.**

### Plan B: Multiple Daily Injections

- Child will receive a fixed dose of \_\_\_\_\_ long-acting insulin at \_\_\_\_\_  Yes  No
- Follow blood glucose monitoring plan above.
- Use \_\_\_\_\_ insulin for meals and snacks. Insulin dose for food is \_\_\_\_\_ unit(s) for meals OR \_\_\_\_\_ unit(s) for every \_\_\_\_\_ grams carbohydrate.

Give injection after the child eats.

- If blood glucose is above target, add correction dose to:  
 Breakfast  Snack  
 Lunch  Snack  
 Other: \_\_\_\_\_

Use the following correction factor \_\_\_\_\_ or this scale:

\_\_\_\_\_ units if BG is \_\_\_\_\_ to \_\_\_\_\_  
 \_\_\_\_\_ units if BG is \_\_\_\_\_ to \_\_\_\_\_  
 \_\_\_\_\_ units if BG is \_\_\_\_\_ to \_\_\_\_\_  
 \_\_\_\_\_ units if BG is \_\_\_\_\_ to \_\_\_\_\_

**Only add correction dose if it has been 3 hours since the last insulin administration.**

### C: Fixed Insulin Doses

- Child will receive a fixed dose of long acting insulin?  Yes  No  
 If yes, give child \_\_\_\_\_ units of \_\_\_\_\_ insulin at \_\_\_\_\_.
- Insulin correction dose at child care ( \_\_\_\_\_ insulin)?  
 Yes  No
- If blood glucose is above target, add correction dose to:  
 Breakfast  Snack  
 Lunch  Snack  
 Other: \_\_\_\_\_

Use the following correction factor \_\_\_\_\_ or the following scale:

\_\_\_\_\_ units if BG is \_\_\_\_\_ to \_\_\_\_\_  
 \_\_\_\_\_ units if BG is \_\_\_\_\_ to \_\_\_\_\_  
 \_\_\_\_\_ units if BG is \_\_\_\_\_ to \_\_\_\_\_  
 \_\_\_\_\_ units if BG is \_\_\_\_\_ to \_\_\_\_\_

**Only add correction dose if it has been 3 hours since the last insulin administration.**

## Managing Very Low Blood Glucose

### Hypoglycemia Plan for Blood Glucose less than \_\_\_\_\_ mg/dL

1. Give 15 grams of fast acting carbohydrate.
2. Recheck blood glucose in 15 minutes.
3. If still below 70 mg/dL, offer 15 grams of fast acting carbohydrate, check again in 15 minutes.
4. When the child's blood glucose is over 70, provide 15g of carbohydrate as snack. Do not give insulin with this snack.
5. **Contact the parent/guardian** any time blood glucose is less than \_\_\_\_\_ mg/dL at child care.

#### Usual symptoms of hypoglycemia for this child include:

- |                                   |   |  |
|-----------------------------------|---|--|
| <input type="checkbox"/> Shaky    | <input type="checkbox"/> Fast heartbeat | <input type="checkbox"/> Sweating          |
| <input type="checkbox"/> Anxious  | <input type="checkbox"/> Hungry         | <input type="checkbox"/> Weakness/Fatigue  |
| <input type="checkbox"/> Headache | <input type="checkbox"/> Blurry vision  | <input type="checkbox"/> Irritable/Grouchy |
| <input type="checkbox"/> Dizzy    | <input type="checkbox"/> Other _____    |  |

1. If you suspect low blood glucose, check blood glucose!
2. If blood glucose is below \_\_\_\_\_, follow the plan above.
3. If the child is unconscious, having a seizure (convulsion) or unable to swallow:
  - Give glucagon. Mix liquid and powder and draw up to the first hash mark on the syringe. Then inject into the thigh. Turn child on side as vomiting may occur.
  - If glucagon is required, administer it promptly. Then, call 911 (or other emergency assistance). After calling 911, contact the parents/guardian. If unable to reach parent, contact diabetes care provider.

## Managing Very High Blood Glucose

### Hyperglycemia Plan for Blood Glucose higher than \_\_\_\_\_ mg/dL

#### Usual symptoms of hyperglycemia for this child include:

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Extreme thirst | <input type="checkbox"/> Very wet diapers, accidents       |  |
| <input type="checkbox"/> Hungry         | <input type="checkbox"/> Warm, dry, flushed skin           | <input type="checkbox"/> Tired or drowsy |
| <input type="checkbox"/> Headache       | <input type="checkbox"/> Blurry vision                     | <input type="checkbox"/> Vomiting**      |
| <input type="checkbox"/> Fruity breath  | <input type="checkbox"/> Rapid, shallow breathing          |  |
| <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Unsteady walk (more than typical) |  |
- \*\*If child is vomiting, contact parents immediately

#### Treatment of hyperglycemia/very high blood glucose:

1. Check for ketones in the:
  - urine
  - blood (parent will provide training)
2. **If ketones are moderate or large**, contact parent. If unable to reach parent, contact diabetes care provider for additional instructions.  
Contact parent if ketones are trace or small:  Yes  No
3. Children with high blood glucose will require additional insulin **if the last dose of insulin was given 3 or more hours earlier**. Consult the insulin plan above for instructions. If still uncertain how to manage high blood glucose, contact the parent.
4. Provide sugar free fluids as tolerated.
5. You may also:
  - Provide carbohydrate free snacks if hungry
  - Delay exercise
  - Change diapers frequently/give frequent access to the bathroom
  - Stay with the child

## Diabetes Dictionary

**Blood glucose** - The main sugar found in the blood and the body's main source of energy. Also called blood sugar. The **blood glucose level** is the amount of glucose in a given amount of blood. It is noted in milligrams in a deciliter, or mg/dL.

**Bolus** - An extra amount of insulin taken to lower the blood glucose or cover a meal or snack.

**Bolus calculator** - A feature of the insulin pump that uses input from a pump user to calculate the insulin dose. The user inputs the blood glucose and amount of carbohydrate to be consumed, and the pump calculates the dose that can be approved by the user.

**Correction Factor** - The drop in blood glucose level, measured in milligrams per deciliter (mg/dl), caused by each unit of insulin taken. Also called **insulin sensitivity factor**.

**Diabetic Ketoacidosis (DKA)** - An emergency condition caused by a severe lack of insulin, that results in the breakdown of body fat for energy and an accumulation of ketones in the blood and urine. Signs of DKA are nausea and vomiting, stomach pain, fruity breath odor and rapid breathing. Untreated DKA can lead to coma and death.

**Fixed dose regimen** - Children with diabetes who use a fixed dose regimen take the same "fixed" doses of insulin at specific times each day. They may also take additional insulin to correct hyperglycemia.

**Glucagon** - A hormone produced in the pancreas that raises blood glucose. An injectable form of glucagon, available by prescription, is used to treat severe hypoglycemia or severely low blood glucose.

**Hyperglycemia** - Excessive blood glucose, greater than 240 mg/dL for children using and insulin pump and greater than 300 mg/dL for children on insulin injections. If untreated, the patient is at risk for **diabetic ketoacidosis (DKA)**.

**Hypoglycemia** - A condition that occurs when the blood glucose is lower than normal, usually less than 70 mg/dL. Signs include hunger, nervousness, shakiness, perspiration, dizziness or light-headedness, sleepiness, and confusion. If left untreated, hypoglycemia may lead to unconsciousness.

**Insulin** - A hormone that helps the body use glucose for energy. The beta cells of the pancreas make insulin. When the body cannot make enough insulin, it is taken by injection or through use of an insulin pump.

**Insulin Pump** - An insulin-delivering device about the size of a deck of cards that can be worn on a belt or kept in a pocket. An insulin pump connects to narrow, flexible plastic tubing that ends with a needle inserted just under the skin. Pump users program the pump to give a steady trickle or constant (basal) amount of insulin continuously throughout the day. Then, users set the pump to release bolus doses of insulin at meals and at times when blood glucose is expected to be higher. This is based on programming done by the user.

**Ketones** - A chemical produced when there is a shortage of insulin in the blood and the body breaks down body fat for energy. High levels of ketones can lead to **diabetic ketoacidosis** and coma.

**Multiple Daily Injection Regimen** - Multiple daily insulin regimens typically include a basal, or long acting, insulin given once per day. A short acting insulin is given by injection with meals and to correct hyperglycemia, or elevated blood glucose, multiple times each day.

**Type 1 Diabetes** - Occurs when the body's immune system attacks the insulin-producing beta cells in the pancreas and destroys them. The pancreas then produces little or no insulin. Type 1 diabetes develops most often in young people but can appear in adults. It is one of the most common chronic diseases diagnosed in childhood.

Physician Signature \_\_\_\_\_

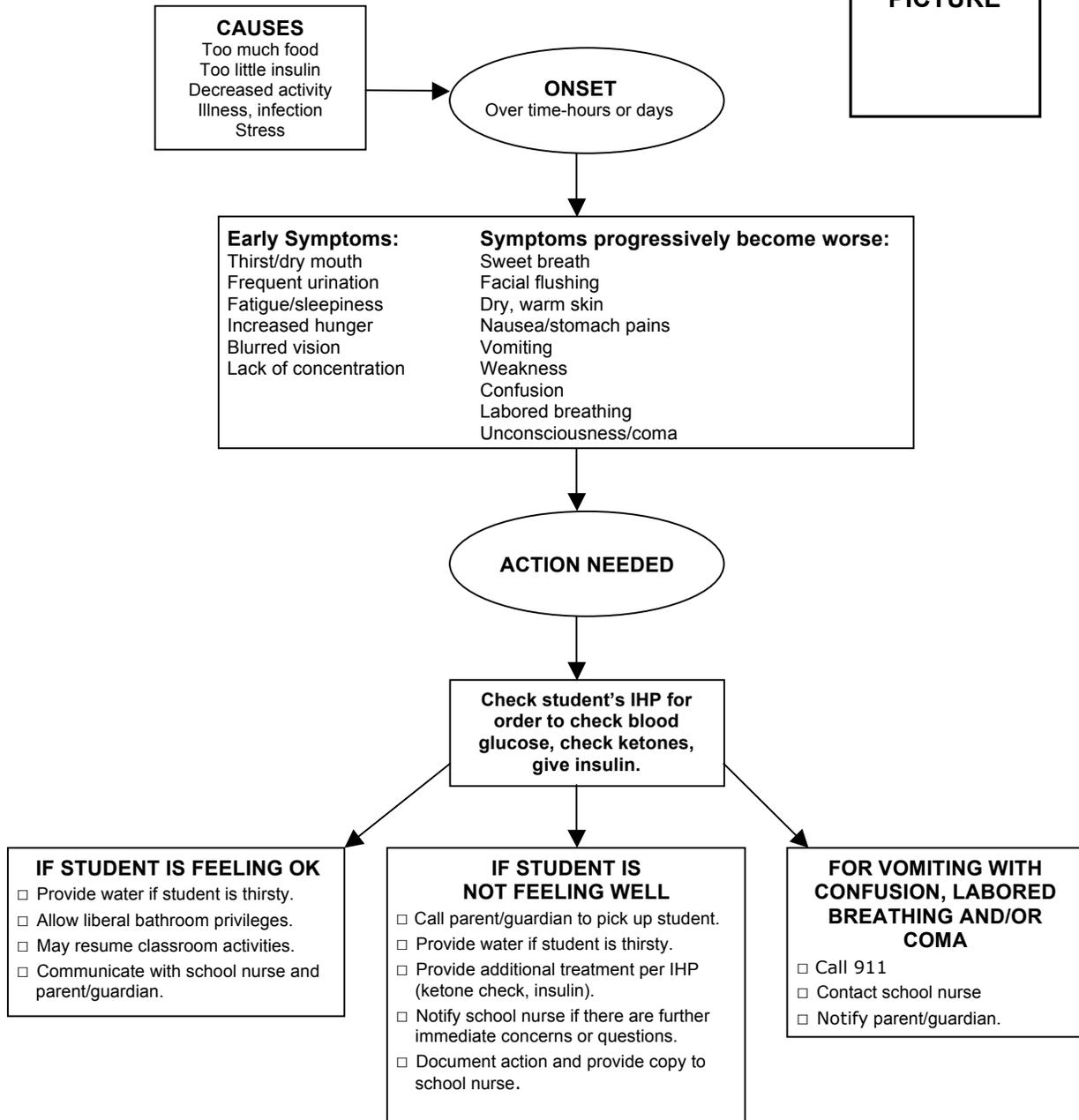
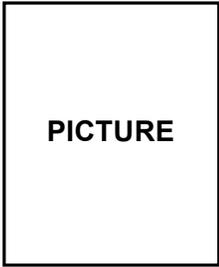


# HIGH BLOOD GLUCOSE (HYPERGLYCEMIA) MANAGEMENT ALGORITHM

Student Name: \_\_\_\_\_

Grade/Teacher: \_\_\_\_\_

School Year/Date & School: \_\_\_\_\_



School nurse: \_\_\_\_\_

Date: \_\_\_\_\_

## LOW BLOOD GLUCOSE (HYPOGLYCEMIA) EMERGENCY CARE PLAN

Student Name: \_\_\_\_\_

Date: \_\_\_\_\_

Grade/Teacher: \_\_\_\_\_

School Year/Date & School: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

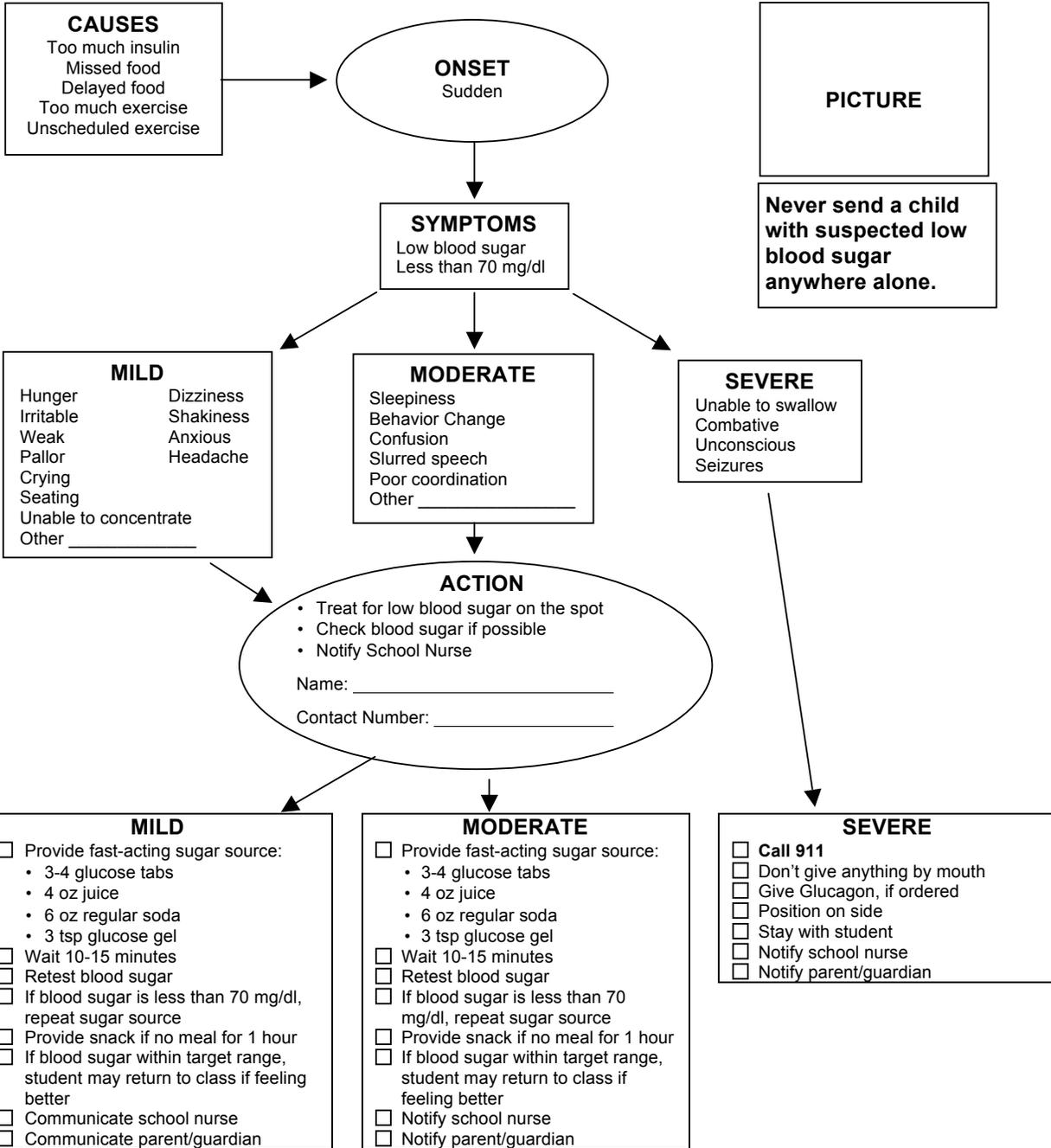
Phone: ( ) \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_

Health Care Provider: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_



School Nurse  
Signature: \_\_\_\_\_

Date: \_\_\_\_\_





# Eco-Healthy Child Care® Checklist

30 easy-to-follow steps that will immediately benefit the health and well-being of the children in your care.



Follow these instructions to get started on creating a healthier environment!

- |  |   |  |   |   |
|--|---|--|---|---|
| <p><b>1.</b><br/>Answer all 30 questions on the checklist.</p> | <p><b>2.</b><br/>Comply with at least 24 of 30 items, including #1, #6 and #11, which are required.</p> | <p><b>3.</b><br/>If you can't answer "true" to 24 items, take steps to make improvements. Visit <a href="http://www.cehn.org/ehcc">www.cehn.org/ehcc</a> for tips and tools.</p> | <p><b>4.</b><br/>Fill out all parts of the Endorsement Form, and obtain both required signatures.</p> | <p><b>5.</b><br/>Send the completed checklist and \$25/\$50 payment to the address indicated.</p> |
|--|---|--|---|---|

All EHCC checklist items comply with *Caring for Our Children: National Health and Safety Performance Standards, 3<sup>rd</sup> Edition*.

TRUE  
FALSE  
?

## Pesticides and Pest Prevention

- 1.** We use non-toxic techniques inside and outside of the facility to prevent and control pests (both insects and weeds). If a serious threat remains and pesticide application is the only viable option, parents and staff are notified in advance and a licensed professional applies the least toxic, effective product at a time when children will have the least exposure to the application area for at least 12 hours (see manufacturer's instructions to ensure 12 hours is enough time). **REQUIRED**
- 2.** We thoroughly wash all fruits and vegetables to avoid possible exposure to pesticides, and we take the opportunity to educate children about the importance of doing so.

## Air Quality

- 3.** We avoid conditions that lead to excess moisture, because moisture contributes to the growth of mold and mildew. We maintain adequate ventilation (which can include exhaust fans and open screened windows). We repair water leaks and keep humidity within a desirable range (30-50%).
- 4.** We do not allow vehicles to idle in our designated parking areas.
- 5.** We do not use scented or unscented candles or air fresheners.
- 6.** During operating hours, we do not permit smoking anywhere on the premises or in sight of children. (Note: For the healthiest environment for children and staff, smoking should not be allowed on the premises at any time). **REQUIRED**

## Household Chemicals

- 7.** We use unscented, biodegradable, non-toxic cleaning products and least-toxic disinfecting and sanitizing products. When disinfectants and sanitizers are required, they are used only for their intended purpose and in strict accordance with all label instructions.
- 8.** We use chlorine bleach only when and where it is required or recommended by state and local authorities. We use it prudently and never use more than necessary.
- 9.** We do not use aerosol sprays of any kind.
- 10.** We use only no-VOC or low-VOC (Volatile Organic Compounds) household paints and do not paint when children are present.

## Lead

- 11.** We use only cold water for drinking, cooking and making baby formula; we flush all cooking and drinking outlets after long periods of non-use; and we clean debris from our outlet screens or aerators on a regular basis. If we suspect that there could be lead in our drinking water, we have our water tested and, if appropriate, use water filtration devices that have been certified to remove lead for additional treatment of drinking water at the outlet. **REQUIRED**



- 12.** Our building was built after 1978 OR 1) We maintain our facility to minimize lead hazards AND 2) We follow the Federal requirements in EPA's *Renovate Right* brochure before painting, remodeling, renovating, or making repairs that disturb paint. We have reviewed how to meet these requirements at [www.cehn.org/files/leadpaint.pdf](http://www.cehn.org/files/leadpaint.pdf).
- 13.** To avoid possible lead exposure, we do not use imported, old or handmade pottery to cook, store or serve food or drinks.
- 14.** To reduce possible exposure to lead-contaminated dirt, we supply a rough mat at the entrance of our facility and encourage the wiping of shoes before entering — or — we are a shoe-free facility.
- 15.** We screen our toys for lead by searching [www.cpsc.gov](http://www.cpsc.gov) or [www.healthystuff.org](http://www.healthystuff.org).

### Mercury

- 16.** We do not use any mercury-containing thermometers or thermostats. Instead we use digital options.
- 17.** We securely store and recycle all used batteries and fluorescent and compact fluorescent light bulbs.

### Furniture and Carpets

- 18.** To avoid possible exposure to flame retardants, we ensure furniture is in good condition without foam or inside stuffing exposed. Stuffed animals, matting, pillows and other foam items are also intact.
- 19.** Furniture is made of solid wood or low-VOC (Volatile Organic Compounds) products, with few items made of particleboard. When purchasing furniture or renovating, we choose either solid wood (new or used) or products that have low VOCs.
- 20.** We do not have wall-to-wall carpeting where children are present.
- 21.** Area rugs are vacuumed daily and cleaned at least twice a year and as needed using biodegradable cleaners.

### Art Supplies

- 22.** We use only non-toxic art supplies approved by the Art and Creative Materials Institute (ACMI). Look for ACMI non-toxic seal 'AP' at [www.acminet.org](http://www.acminet.org).

### Plastics and Plastic Toys

- 23.** We avoid toys made out of soft plastic vinyl (such as vinyl dolls, beach balls, and "rubber ducky" chew toys). We buy only those labeled "PVC-free" and "phthalate-free".
- 24.** When using a microwave, we never heat children's food in plastic containers, plastic wrap or plastic bags.
- 25.** We never use baby bottles, sippy cups or drinking cups made with BPA (Bisphenol A). Instead, we choose products made of glass, or plastic that is labeled 'BPA free'.

### Treated Playground Equipment

- 26.** We do not have playground equipment made of CCA treated wood (pre-2006) — or — if we do, we apply 2 coats of waterproof stain or sealant at least once a year.

### Radon

- 27.** We have tested our facility for radon. If elevated levels of radon are found, we take action to mitigate. We have visited [www.epa.gov/radon](http://www.epa.gov/radon) for resources, and have researched state requirements and guidelines to learn more.

### Recycling and Garbage Storage

- 28.** We recycle all paper, cardboard, glass, aluminum and plastic bottles.
- 29.** We keep our garbage covered at all times to avoid attracting pests and to minimize odors.

### Education and Awareness

- 30.** We create opportunities to educate the families we serve on eco-healthy practices.

For more information on any checklist items, visit [www.cehn.org/ehcc/resources](http://www.cehn.org/ehcc/resources) For more information on any checklist items, visit [www.cehn.org/ehcc/resources](http://www.cehn.org/ehcc/resources)





Thank you for working to make your child care Eco-Healthy!

**1 Verify your responses** (both signatures required):

“The information provided on this Eco-Healthy Child Care® Endorsement Checklist is true to the best of my knowledge.”

 **1. FACILITY OWNER OR DIRECTOR** ..... date

 **2. PARENT OR NON-EMPLOYEE WITNESS** ..... date

**3 Provide fee and confirmation of EHCC participation**

As part of EHCC quality control, a limited number of endorsed sites are randomly selected for a free site assessment; selected sites receive at least 48 hours notice. By submitting this endorsement form and payment, you also agree to a possible site assessment conducted by EHCC staff. Please visit [www.cehn.org/onsite](http://www.cehn.org/onsite) to find out more.

By meeting the criteria outlined above, including the necessary signatures, and submitting the \$25/\$50 endorsement fee, your facility will receive the 2-year Eco-Healthy Child Care® endorsement, including certificate, Eco-Healthy Tips, inclusion on the EHCC website, and other EHCC support for 2 years.

**4 Mail form and payment to:**

EHCC/CEHN  
110 Maryland Avenue NE, Suite 402  
Washington DC, 20002

**2 Please record your facility information:**

.....	.....	.....
Facility name		# of children served
.....		
Street address or P.O. Box		
.....		
City	State	Zip code
.....		
Contact name	Phone	
.....		
Contact email	Facility website	

- Choose one:     Family Child Care     Center-based
- Please **do not** post my facility information on the website
- I **do not** want to receive EHCC's bi-monthly email tips

**Fees**

The 2-year endorsement processing fee:

- facilities licensed to care for 1-20 children is **\$25**
- facilities licensed to care for 21+ children is **\$50**

**Please indicate method of payment**

- Enclosed is our \$25/\$50 check or money order made out to EHCC/CEHN
- We've paid our \$25/\$50 payment via credit card at **[www.cehn.org/ehcc/payment](http://www.cehn.org/ehcc/payment)**  
Our payment confirmation number \_\_\_\_\_

**Renewal Incentive:** Previously-endorsed facilities that renew their endorsement on time (both checklist AND payment received by CEHN before one's current endorsement expires) may deduct \$10 from their endorsement fee. (The dates of endorsement are listed on the EHCC endorsement certificate.)

**FOR VERIFICATION • OFFICE USE ONLY**

.....	.....	.....
Approved by (signature)	Date	Center #

## Be Eco-Healthy!

life are critical to shaping their future health and development. As a child care provider, small changes you make can have a big impact on the children in your care. By reducing toxins, you help prevent illnesses like asthma, certain learning disabilities and even some forms of cancer. Learn more at [www.cehn.org/ehcc](http://www.cehn.org/ehcc).

**Thank you for taking steps to make your child care program Eco-Healthy!**



[www.cehn.org/ehcc](http://www.cehn.org/ehcc)

EHCC is a program of Children's Environmental Health Network created by Oregon Environmental Council.



# Health and Safety Checklist for Early Care and Education Programs:

Based on *Caring for Our Children*  
National Health and Safety Performance Standards,  
Third Edition

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*Developed by the California Childcare Health Program  
Funded by the UCSF School of Nursing  
2014*

**Health and Safety Checklist for Early Care and Education Programs:  
Based on *Caring for Our Children National Health and Safety Performance Standards, Third Edition***

Developed by the California Childcare Health Program (CCHP)  
University of California San Francisco (UCSF) School of Nursing  
2014

The UCSF CCHP Health and Safety Checklist Development Team is grateful to the many individuals who shared their expertise and spent considerable time developing this Checklist.

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**PILOT STUDY**

We would like to thank the many ECE programs in Arizona, North Carolina and California for their participation in the pilot testing of the Checklist.

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We would also like to thank the child care health consultants, child care health advocates and other health and safety experts who participated in the online survey to identify CFOC3 standards to include in the Checklist.

**GRAPHIC DESIGN:** Mara Gendell, California Childcare Health Program

**FUNDING:** This study was funded by the School of Nursing at the University of California, San Francisco.

# Health and Safety Checklist for Early Care and Education Programs:

## Based on *Caring for Our Children* National Health and Safety Performance Standards, Third Edition

Child Care Center: \_\_\_\_\_

Classroom: \_\_\_\_\_

Classroom type (infant/toddler, preschool): \_\_\_\_\_

Date: (month/day/year) \_\_ \_\_/ \_\_ \_\_/ \_\_ \_\_ \_\_ \_\_

Observer Name: \_\_\_\_\_

Time Begin: \_\_ \_\_: \_\_ \_\_ AM/PM

Time End: \_\_ \_\_: \_\_ \_\_ AM/PM

### Ratings:

Code	Meaning	Definition
1	Never	None of the components of the item are met.
2	Sometimes	Less than or 50% ( $\leq 50\%$ ) of the components in the item are met.
3	Usually	More than 50% ( $> 50\%$ ) but less than 100% of the components in the item are met.
4	Always	Every component in the item is met (100%).
NA	Not Applicable	The item is not applicable (NA) to the classroom/program. Explain why it is rated NA in the 'notes' section.
N Op	No Opportunity to Observe	There was no opportunity (N Op) to observe this item. Explain why it is rated N Op in the 'notes' section.

### Notes:

- An asterisk (\*) means you may need to talk to the director or a staff member to ask where to find an item or product.
- At the end of each subscale there is a space to list and rate other related standards and/or regulations that may apply.
- When a field/box is shaded grey, the rating choice is not an option.

*This checklist does not cover all health and safety concerns or replace each child care program's responsibility to meet local, state, and federal health and safety requirements.*

## FACILITIES: Emergencies, Medications, Equipment and Furnishings

### Emergencies

	Never	Sometimes	Usually	Always	Not Applicable	No Opportunity
1. A sign-in/sign-out system tracks who (other than children) enters and exits the facility. It includes name, contact number, purpose of visit (for example, parent/guardian, vendor, guest, consultant) and time in and out. ( <a href="#">Std. 9.2.4.7</a> )	1	2	3	4		
<b>NOTES</b>						
2. Phone numbers to report child abuse and neglect (Child Protective Services) are clearly posted where any adult can easily see them. ( <a href="#">Std. 3.4.4.1</a> )	1	2	3	4		
<b>NOTES</b>						
3. Phone number for the Poison Center is posted where it can be seen in an emergency (for example, next to the phone). ( <a href="#">Stds. 5.2.9.1, 5.2.9.2</a> )	1	2	3	4		
<b>NOTES</b>						
4. Fire extinguishers are inspected annually. Check date on fire extinguisher tag. ( <a href="#">Std. 5.1.1.3</a> )	1	2	3	4		
<b>NOTES</b>						
5. Each building or structure has at least two unobstructed exits leading to an open space at the ground floor. ( <a href="#">Std. 5.1.4.1</a> )	1	2	3	4		
<b>NOTES</b>						
6. A smoke detector system or alarm in working order is in each room or place where children spend time. ( <a href="#">Std. 5.2.5.1</a> )	1	2	3	4		
<b>NOTES</b>						
7. Carbon monoxide detectors are outside of sleeping areas. ( <a href="#">Std. 5.2.9.5</a> )	1	2	3	4	NA	
<b>NOTES</b>						
8. *First aid supplies are well-stocked in each location where children spend time. ( <a href="#">Std. 5.6.0.1</a> )	1	2	3	4		
<b>NOTES</b>						
9. *First aid supplies are kept in a closed container, cabinet or drawer that is labeled. They are stored out of children's reach and within easy reach of staff. ( <a href="#">Std. 5.6.0.1</a> )	1	2	3	4		
<b>NOTES</b>						
10. *A well-stocked first aid kit is ready for staff to take along when they leave the facility with children (for example, when going on a walk, a field trip or to another location). ( <a href="#">Std. 5.6.0.1</a> )	1	2	3	4	NA	
<b>NOTES</b>						
List and rate other federal, state, local and/or accreditation standards/regulations that may apply:						
	1	2	3	4		N Op
<b>NOTES</b>						

## Medications

	Never	Sometimes	Usually	Always	Not Applicable	No Opportunity
11. *Medications are stored in an organized fashion and are not expired. They are stored at the proper temperature, (for example, in the refrigerator or at room temperature according to instructions) out of children's reach and separated from food. ( <a href="#">Std. 3.6.3.2</a> )	1	2	3	4	NA	
<b>NOTES</b>						
12. *Over-the-counter medications are in the original containers. They are labeled with the child's name. Clear written instructions from the child's health care provider are with the medication (excluding non-prescription sunscreen, insect repellent, and diaper cream). ( <a href="#">Stds. 3.6.3.1, 3.6.3.2</a> )	1	2	3	4	NA	N Op
<b>NOTES</b>						
13. *Prescription medications are in their original, child resistant container, labeled with child's name, date filled, prescribing health care provider's name, pharmacy name and phone number, dosage, instructions, and warnings. ( <a href="#">Stds. 3.6.3.1, 3.6.3.2</a> )	1	2	3	4	NA	N Op
<b>NOTES</b>						
List and rate other federal, state, local and/or accreditation standards/regulations that may apply:						
	1	2	3	4		N Op
<b>NOTES</b>						

## Equipment and Furnishings — Indoors and Outdoors ý

14. There is fresh air provided by windows or a ventilation system. There are no odors or fumes (for example, mold, urine, excrement, air fresheners, chemicals, pesticides.) ( <a href="#">Stds. 5.2.1.1, 3.3.0.1, 5.2.8.1</a> )	1	2	3	4		
<b>NOTES</b>						
15. Windows accessible to children open less than 4 inches or have window guards so that children cannot climb out. ( <a href="#">Std. 5.1.3.2</a> )	1	2	3	4	NA	
<b>NOTES</b>						
16. There are no unvented gas or oil heaters or portable kerosene space heaters. ( <a href="#">Std. 5.2.1.10</a> )	1			4		
<b>NOTES</b>						
17. Gas cooking appliances are not used for heating purposes. Charcoal grills are not used indoors. ( <a href="#">Std. 5.2.1.10</a> )	1			4	NA	
<b>NOTES</b>						
18. Portable electric space heaters are not used with an extension cord and are not left on when unattended. They are placed on the floor at least three feet from curtains, papers, furniture and/or any flammable object and are out of children's reach. ( <a href="#">Std. 5.2.1.11</a> )	1	2	3	4	NA	N Op
<b>NOTES</b>						
19. All electrical outlets within children's reach are tamper resistant or have safety covers attached by a screw or other means that cannot be removed by a child. ( <a href="#">Std. 5.2.4.2</a> )	1	2	3	4	NA	
<b>NOTES</b>						
20. All cords from electrical devices or appliances are out of children's reach. ( <a href="#">Stds. 4.5.0.9, 5.2.4.4</a> )	1	2	3	4		
<b>NOTES</b>						

Equipment and Furnishings — Indoors and Outdoors — *Continued*

	Never	Sometimes	Usually	Always	Not Applicable	No Opportunity
21. *There are no firearms, pellet or BB guns, darts, bows and arrows, cap pistols, stun guns, paint ball guns or objects manufactured for play as toy guns visible. ( <a href="#">Std. 5.5.0.8</a> )	1			4		
<b>NOTES</b>						
22. Plastic bags, matches, candles and lighters are stored out of children’s reach. ( <a href="#">Stds. 5.5.0.7, 5.5.0.6</a> )	1	2	3	4		
<b>NOTES</b>						
23. There are no latex balloons (inflated, underinflated, or not inflated) or inflated objects that are treated as balloons, (for example, inflated latex gloves) on site. ( <a href="#">Stds. 6.4.1.5, 6.4.1.2</a> )	1			4		
<b>NOTES</b>						
24. Bathtubs, buckets, diaper pails and other open containers of water are emptied immediately after use. ( <a href="#">Std. 6.3.5.2</a> )	1	2	3	4	NA	
<b>NOTES</b>						
25. Children do not play in areas where there is a body of water unless a caregiver/teacher is within an arm’s length providing “touch supervision”. Bodies of water include tubs, pails, sinks, toilets, swimming pools, ponds, irrigation ditches, and built-in wading pools. ( <a href="#">Std. 2.2.0.4</a> )	1			4	NA	N Op
<b>NOTES</b>						
26. Hot liquids and food (more than 120°F) are kept out of children’s reach. Adults do not consume hot liquids in child care areas. ( <a href="#">Std. 4.5.0.9</a> )	1	2	3	4		
<b>NOTES</b>						
27. Equipment and play areas (including water play areas) do not have the following: sharp points or corners; splinters; glass; protrusions that may catch a child’s clothing (for example, nails, pipes, wood ends, long bolts); flaking paint; loose or rusty parts; small parts that may become detached or present a choking, aspiration, or ingestion hazard; strangulation hazards (for example, straps or strings); or components that can snag skin, pinch, shear, or crush body tissues. ( <a href="#">Stds. 5.3.1.1, 6.2.1.9, 6.3.1.1</a> )	1	2	3	4		
<b>NOTES</b>						
28. All openings in play or other equipment are smaller than 3.5 inches or larger than 9 inches. There are no rings on long chains. ( <a href="#">Stds. 6.2.1.9, 5.3.1.1</a> )	1	2	3	4		
<b>NOTES</b>						
29. All openings in play or other equipment are smaller than 3/8 of an inch or larger than 1 inch. ( <a href="#">Std. 6.2.1.9</a> )	1	2	3	4		
<b>NOTES</b>						
30. Climbing equipment is placed over and surrounded by a shock-absorbing surface. Loose fill materials (for example, sand, wood chips) are raked to maintain proper depth/distribution. Unitary shock-absorbing surfaces meet current ASTM International standards and/or CPSC Standards. <a href="http://www.astm.org/Standards/F2223.htm">http://www.astm.org/Standards/F2223.htm</a> , <a href="http://www.cpsc.gov/PageFiles/122149/325.pdf">http://www.cpsc.gov/PageFiles/122149/325.pdf</a> ( <a href="#">Std. 6.2.3.1, Appendix Z</a> )	1	2	3	4	NA	N Op
<b>NOTES</b>						
31. Fall zones extend at least 6 feet beyond the perimeter of stationary climbing equipment. ( <a href="#">Std. 6.2.3.1</a> )	1	2	3	4	NA	N Op
<b>NOTES</b>						
32. Equipment and furnishings are sturdy and in good repair. There are no tip-over or tripping hazards. ( <a href="#">Std. 5.3.1.1</a> )	1	2	3	4		
<b>NOTES</b>						

Equipment and Furnishings — Indoors and Outdoors — *Continued*

	Never	Sometimes	Usually	Always	Not Applicable	No Opportunity
33. There is no hazardous equipment (for example, broken equipment, lawn mowers, tools, tractors, trampolines) accessible to children. ( <a href="#">Std. 5.7.0.4</a> , <a href="#">6.2.4.4</a> )	1			4		
<b>NOTES</b>						
34. Open sides of stairs, ramps, porches, balconies and other walking surfaces, with more than 30 inches to fall, have guardrails or protective barriers. The guardrails are at least 36 inches high. ( <a href="#">Std. 5.1.6.6</a> )	1	2	3	4	NA	
<b>NOTES</b>						
35. Children one year of age and older wear helmets when riding toys with wheels (for example, tricycles, bikes) or using any wheeled equipment (for example, rollerblades, skateboards). Helmets fit properly and meet CPSC standards. Children take off helmets after riding or using wheeled toys or equipment. ( <a href="#">Std. 6.4.2.2</a> )	1	2	3	4	NA	N Op
<b>NOTES</b>						

Equipment and Furnishings — Outdoors Only

36. Children play outdoors each day. Children stay inside only if weather poses a health risk (for example, wind chill factor at or below minus 15°F, heat index at or above 90°F). ( <a href="#">Std. 3.1.3.2</a> )	1	2	3	4		N Op
<b>NOTES</b>						
37. Outdoor play areas are enclosed with a fence or natural barriers that allow caregivers/teachers to see children. Openings in fences and gates are no larger than 3.5 inches. ( <a href="#">Std. 6.1.0.8</a> )	1	2	3	4	NA	N Op
<b>NOTES</b>						
38. Enclosures outside have at least two exits, one being remote from the building. ( <a href="#">Std. 6.1.0.8</a> )	1	2	3	4	NA	N Op
<b>NOTES</b>						
39. Each gate has a latch that cannot be opened by children. Outdoor exit gates are equipped with self-closing, positive latching closure mechanisms that cannot be opened by children. ( <a href="#">Std. 6.1.0.8</a> )	1	2	3	4	NA	N Op
<b>NOTES</b>						
40. Shade is provided outside (for example, trees, tarps, umbrellas). Children wear hats or caps with a brim to protect their faces from the sun if they are not in a shaded area. ( <a href="#">Std. 3.4.5.1</a> )	1	2	3	4	NA	N Op
<b>NOTES</b>						
41. Broad spectrum sun screen with SPF of 15 or higher is available for use. ( <a href="#">Std. 3.4.5.1</a> )	1			4		
<b>NOTES</b>						
List and rate other federal, state, local and/or accreditation standards/regulations that may apply:						
	1	2	3	4		N Op
<b>NOTES</b>						

# SUPERVISION, INTERACTION and ACTIVITY

## Interaction and Physical Activity

Age	Maximum Child: Staff Ratio	Maximum Group Size	Never	Sometimes	Usually	Always	Not Applicable	No Opportunity
≤12 months	3:1	6						
13-35 months	4:1	8						
3-year-olds	7:1	14						
4-year-olds	8:1	16						
5-year-olds	8:1	16						
42. Ratios: Indoors: Time (hour/min): ____ / ____ Ages of children observed: (check all that apply) ≤12 months    2 years    3 years    4 years    5+ years # of children ____ # of staff ____ child/staff ratio: ____:____ (Std. 1.1.1.2) For Family Child Care Programs, see CFOC3 Stds. <a href="#">1.1.1.1</a> , <a href="#">1.1.1.2</a>			1			4		
<b>NOTES</b>								
43. Ratios: Outdoors: Time (hour/min): ____ / ____ Ages of children observed: (check all that apply) ≤12 months    2 years    3 years    4 years    5+ years # of children ____ # of staff ____ child/staff ratio: ____:____ (Std. 1.1.1.2) For Family Child Care Programs, see CFOC3 Stds. <a href="#">1.1.1.1</a> , <a href="#">1.1.1.2</a>			1			4		N Op
<b>NOTES</b>								
44. Caregivers/Teachers directly supervise children by sight and hearing at all times. This includes indoors, outdoors and when children are sleeping, going to sleep or waking up. (Std. 2.2.0.1)			1	2	3	4		
<b>NOTES</b>								
45. Caregivers/Teachers encourage positive behavior and guide children to develop self-control. Caregivers/Teachers model desired behavior. "Time out" is only used for persistent, unacceptable behavior. (Std. 2.2.0.1)			1	2	3	4		
<b>NOTES</b>								
46. Caregivers/Teachers support children to learn appropriate social skills and emotional responses. There are daily routines and schedules. (Std. 2.2.0.6)			1	2	3	4		
<b>NOTES</b>								
47. There is no physical or emotional abuse or maltreatment of a child. There is no physical punishment or threat of physical punishment of a child. (Std. 2.2.0.9)			1			4		
<b>NOTES</b>								
48. Caregivers/Teachers do not use threats or humiliation (public or private). There is no profane or sarcastic language. There are no derogatory remarks made about a child or a child's family. (Std. 2.2.0.9)			1	2	3	4		
<b>NOTES</b>								
49. Children are not physically restrained unless their safety or that of others is at risk. (Std. 2.2.0.10)			1			4		
<b>NOTES</b>								
50. Physical activity/outdoor time are not taken away as punishment. (Std. 2.2.0.9)			1			4		
<b>NOTES</b>								
51. Children engage in moderate to vigorous physical activities such as running, climbing, dancing, skipping and jumping. All children (including infants) have opportunities to develop and practice gross motor and movement skills. (Std. 3.1.3.1)			1	2	3	4		
<b>NOTES</b>								

Interaction and Physical Activity — *Continued*

	Never	Sometimes	Usually	Always	Not Applicable	No Opportunity
52. There are structured or adult-led physical activities and games that promote movement for children. ( <a href="#">Std. 3.1.3.1</a> )	1	2	3	4		
<b>NOTES</b>						
List and rate other federal, state, local and/or accreditation standards/regulations that may apply:						
	1	2	3	4		N Op
<b>NOTES</b>						

Nutrition: Eating and Drinking

53. Individual children’s food allergies are posted where they can be seen in the classroom and wherever food is served. ( <a href="#">Std. 4.2.0.10</a> )	1	2	3	4	NA	
<b>NOTES</b>						
54. Children two years of age and older are served skim or 1% milk. ( <a href="#">Std. 4.9.0.3</a> )	1	2	3	4	NA	N Op
<b>NOTES</b>						
55. Drinking water is available, indoors and outdoors, throughout the day for children over 6 months of age. ( <a href="#">Std. 4.2.0.6</a> )	1	2	3	4		
<b>NOTES</b>						
56. A variety of nourishing foods is served at meals and snacks. Nourishing foods include fruits, vegetables, whole and enriched grains, protein and dairy. ( <a href="#">Std. 4.2.0.3</a> )	1	2	3	4	NA	N Op
<b>NOTES</b>						
57. Foods that are choking hazards are not served to children under 4 years of age. This includes hot dogs and other meat sticks (whole or sliced into rounds), raw carrot rounds, whole grapes, hard candy, nuts, seeds, raw peas, hard pretzels, chips, peanuts, popcorn, rice cakes, marshmallows, spoonfuls of peanut butter or chunks of meat larger than can be swallowed whole. ( <a href="#">Std. 4.5.0.10</a> )	1			4		
<b>NOTES</b>						
58. Children are always seated while eating. ( <a href="#">Std. 4.5.0.10</a> )	1	2	3	4		
<b>NOTES</b>						
59. Food is not used or withheld as a bribe, reward, or punishment. ( <a href="#">Std.2.2.0.9</a> )	1			4		
<b>NOTES</b>						
List and rate other federal, state, local and/or accreditation standards/regulations that may apply:						
	1	2	3	4		N Op
<b>NOTES</b>						

## SANITATION: Personal Hygiene, Environmental Health

### Personal Hygiene — Handwashing

	Never	Sometimes	Usually	Always	Not Applicable	No Opportunity
60. Situations or times that children and staff should perform hand hygiene are posted in all food preparation, hand hygiene, diapering, and toileting areas. ( <a href="#">Std.3.2.2.1</a> )	1	2	3	4		
<b>NOTES</b>						
61. Handwashing Procedures — <i>Staff</i> <ul style="list-style-type: none"> <li>- Moisten hands with water and apply soap (not antibacterial).</li> <li>- Rub hands together into a soapy lather for 20 seconds.</li> <li>- All hand surfaces are washed including fronts and backs and between fingers from wrists to finger tips.</li> <li>- Hands are rinsed with running water and dried with a paper or single use cloth towel.</li> </ul> ( <a href="#">Std. 3.2.2.2</a> )	1	2	3	4		
<b>NOTES</b>						
62. Handwashing Procedures — <i>Children</i> Children wash their hands or have their hands washed. <ul style="list-style-type: none"> <li>- Moisten hands with water and apply soap (not antibacterial).</li> <li>- Rub hands together into a soapy lather for 10 to 20 seconds.</li> <li>- All hand surfaces are washed including fronts and backs and between fingers from wrists to finger tips.</li> <li>- Hands are rinsed with running water and dried with a paper or single use cloth towel.</li> </ul> ( <a href="#">Std. 3.2.2.2</a> )	1	2	3	4		
<b>NOTES</b>						
63. Caregivers/Teachers help children wash their hands when children can stand but cannot wash their hands by themselves. Children's hands hang freely under the running water either at a child level sink or at a sink with a safety step. ( <a href="#">Std. 3.2.2.3</a> )	1	2	3	4		
<b>NOTES</b>						
64. Adults and children only use alcohol-based sanitizers as an alternative to handwashing with soap and water, if hands are not visibly soiled. Hand sanitizers are only used for children over 24 months with adult supervision. ( <a href="#">Stds. 3.2.2.2, 3.2.2.3</a> )	1	2	3	4	NA	N Op
<b>NOTES</b>						

## Personal Hygiene — Toothbrushing

	Never	Sometimes	Usually	Always	Not Applicable	No Opportunity
65. When toothbrushes are present, they are not worn or frayed. Fluoride toothpaste is present. ( <a href="#">Std. 3.1.5.1</a> )	1	2	3	4	NA	
<b>NOTES</b>						
66. *Except in the case of children who are known to brush their teeth twice a day at home, caregivers/teachers brush children's teeth or monitor tooth brushing activities at least once during the hours that the child is in child care. ( <a href="#">Std. 3.1.5.1</a> )	1	2	3	4	NA	N Op
<b>NOTES</b>						

## Food Safety/Food Handling

67. The food preparation area of the kitchen is separate from eating, play, laundry, toilet, bathroom, and diapering areas. No animals are allowed in the food preparation area. ( <a href="#">Std. 4.8.0.1</a> )	1	2	3	4	NA	
<b>NOTES</b>						
68. The food preparation area is separated from child care areas by a door, gate, counter, or room divider. ( <a href="#">Std. 4.8.0.1</a> )	1			4	NA	
<b>NOTES</b>						
69. There is no home-canned food or food in cans without labels. Food from dented, rusted, bulging or leaking cans is not used. ( <a href="#">Std. 4.9.0.3</a> )	1	2	3	4	NA	
<b>NOTES</b>						
70. Meat, fish, poultry, milk, and egg products are refrigerated or frozen before use. Refrigerators have a thermometer and are kept at 41°F or lower. ( <a href="#">Std. 4.9.0.3</a> )	1	2	3	4	NA	
<b>NOTES</b>						
71. Meat product labels state they are from government-inspected sources and/or dairy product labels state that they are pasteurized. ( <a href="#">Std. 4.9.0.3</a> )	1	2	3	4	NA	N Op
<b>NOTES</b>						
72. All fruits and vegetables are washed thoroughly with water prior to use. ( <a href="#">Std. 4.9.0.3</a> )	1	2	3	4	NA	N Op
<b>NOTES</b>						
73. Store bought fruit juice labels state the juice is pasteurized. Fruit and vegetable juices squeezed on-site are squeezed just prior to serving. ( <a href="#">Std. 4.9.0.3</a> )	1	2	3	4	NA	
<b>NOTES</b>						
74. Food surfaces (for example, dishes, utensils, dining tables, high chair trays, cutting boards) and/or objects intended for the mouth (for example, pacifiers and teething toys) are sanitized. A dishwasher is used or an EPA registered sanitizer is used according to label instructions for sanitizing. ( <a href="#">Std. 3.3.0.1</a> )	1	2	3	4		
<b>NOTES</b>						

## Environmental Health

	Never	Sometimes	Usually	Always	Not Applicable	No Opportunity
75. Kitchen equipment is clean and in working order. Food surfaces are in good repair and free of cracks and crevices. Food surfaces are made of non-porous, smooth material and are kept clean and sanitized. ( <a href="#">Std. 4.8.0.3</a> )	1	2	3	4	NA	N Op
<b>NOTES</b>						
76. There are no cracks or holes in walls, ceilings, floors or screens. ( <a href="#">Std. 5.2.8.1</a> )	1	2	3	4		
<b>NOTES</b>						
77. There is no clutter, trash, water damage, standing water or leaking pipes. Pest breeding areas are not on site. ( <a href="#">Std. 5.2.8.1</a> )	1	2	3	4		
<b>NOTES</b>						
78. Objects and surfaces are kept clean of dirt, debris and sticky films. ( <a href="#">Std. 3.3.0.1</a> )	1	2	3	4		
<b>NOTES</b>						
79. Hard, non-porous surfaces soiled with potentially infectious body fluid (for example, toilets, diaper changing tables) are disinfected. An EPA registered disinfectant is used according to label instructions. ( <a href="#">Std. 3.3.0.1</a> )	1	2	3	4		N Op
<b>NOTES</b>						
80. There are disposable gloves available for handling blood and blood-containing body fluids. ( <a href="#">Std. 3.2.3.4</a> )	1			4		
<b>NOTES</b>						
81. *Infectious waste (for example soiled diapers, blood) and toxic waste (for example, used batteries, fluorescent light bulbs) are stored separately from other waste. ( <a href="#">Stds. 5.2.7.6, 5.2.9.1</a> )	1	2	3	4		N Op
<b>NOTES</b>						
82. Sanitizing and disinfecting are not done when children are nearby. ( <a href="#">Std. 3.3.0.1</a> )	1	2	3	4		N Op
<b>NOTES</b>						
83.*Pesticides are not applied when children are present. ( <a href="#">Std. 5.2.8.1</a> )	1	2	3	4		
<b>NOTES</b>						
84. *Toxic substances are stored in the original, labeled containers. Material Safety Data Sheets (MSDS) are on site for each toxic substance/chemical. ( <a href="#">Std. 5.2.9.1</a> )	1	2	3	4	NA	N Op
<b>NOTES</b>						
85. *Toxic substances are inaccessible to children and stored in a locked room or cabinet when not in active use. Bleach solutions are labeled with contents and date mixed. ( <a href="#">Stds. 5.2.9.1, 5.2.8.1, 3.2.3.4</a> )	1	2	3	4		
<b>NOTES</b>						
List and rate other federal, state, local and/or accreditation standards/regulations that may apply:						
	1	2	3	4		N Op
<b>NOTES</b>						

## POOLS, SPAS and HOT TUBS

Does this program have a pool, spa or hot tub or other water hazard?

Yes: If yes, complete the items below. No: If no, go to the Infants and Toddlers Section.

This facility has the following water hazards: (check all that apply)

Swimming Pool    Hot Tub    Stationary Wading Pool    Pond    Other\_\_\_\_\_

Developmental Levels		Child: Staff Ratios	Never	Sometimes	Usually	Always	Not Applicable	No Opportunity
Infants		1:1						
Toddlers		1:1						
Preschoolers		4:1						
School-age Children		6:1						
86. Ratios: Ages of children observed: (check all that apply) ≤12 months    1 year    2 years    3 years    4 years    5+ years Location _____ Time of Day (hour/min): ____/____ # of children ____ # of staff ____ child/staff ratio: ____:____ (Std. 1.1.1.5)			1			4		N Op
<b>NOTES</b>								
87. All outdoor water hazards are enclosed with a fence at least 4-6 feet high that comes within 3½ inches from the ground. Exits and entrances around bodies of water have self-closing, positive latching gates or doors. The locking devices are a minimum of 55 inches from the ground or floor. (Stds. 6.1.0.6, 6.3.1.1)			1	2	3	4		N Op
<b>NOTES</b>								
88. When not in use, in-ground and above-ground swimming pools, spas, hot tubs or wading pools are covered with a safety cover. The cover meets the ASTM International standards. (Std. 6.3.1.4)			1			4	NA	N Op
<b>NOTES</b>								
List and rate other federal, state, local and/or accreditation standards/regulations that may apply:								
			1	2	3	4		N Op
<b>NOTES</b>								

## INFANTS and TODDLERS: Personal Relationships, Diapering, Injury Prevention

Are there children under 36 months of age in this program?

Yes: If yes, complete the items below. No: If no, you have completed the Checklist.

Infants and Toddlers — Personal Relationships

89. Caregivers/Teachers smile, talk, touch, hold, sing and/or play with children during daily routines, such as diapering, feeding and eating. (Std. 2.1.2.1)	1	2	3	4		
<b>NOTES</b>						
90. Caregivers/Teachers comfort children who are upset. Caregivers/Teachers are aware of and respond to children's feelings. (Std. 2.1.2.1)	1	2	3	4		
<b>NOTES</b>						

## Infants and Toddlers — Diapering

	Never	Sometimes	Usually	Always	Not Applicable	No Opportunity
91. Caregivers/Teachers follow diaper changing procedures below: <ul style="list-style-type: none"> <li>- Caregiver/Teacher has one hand on the child at all times.</li> <li>- Non-absorbent paper liner, large enough to cover the changing surface from the child's shoulders to beyond the child's feet, is used.</li> <li>- Clothing is removed or otherwise kept from contact with the contents of the diaper during the change.</li> <li>- Child is cleaned of stool and urine, front to back, with a fresh wipe for each swipe.</li> <li>- Soiled diapers placed in a plastic-lined, covered, hands-free can.</li> <li>- If reusable cloth diapers are used, soiled diaper is put in a plastic bag or into a plastic-lined, hands-free covered can.</li> <li>- A fresh wipe is used to clean the hands of the caregiver and another fresh wipe to clean the hands of the child before putting on a new diaper and dressing the child.</li> <li>- The child's hands are washed according to the procedure in item #62 before returning the child to a supervised area.</li> <li>- Diaper changing surface is cleaned and disinfected with an EPA registered disinfectant after each diaper change.</li> <li>- Disinfectant is put away, out of children's reach.</li> <li>- Caregivers'/Teachers' hands are washed after diapering procedure is complete according to the procedure in item #61. (<a href="#">Stds. 3.2.1.4</a>, <a href="#">3.2.3.4</a>)</li> </ul>	1	2	3	4	NA	N Op
<b>NOTES</b>						
92. Current diaper changing procedures as listed in item #91 are posted in the diaper changing area(s). ( <a href="#">Std. 3.2.1.4</a> )	1	2	3	4	NA	N Op
<b>NOTES</b>						

## Infants and/or Toddlers — Injury Prevention

93. Strings, cords, ribbons, ties and straps long enough to encircle a child's neck are out of children's reach. ( <a href="#">Std. 3.4.6.1</a> )	1	2	3	4		
<b>NOTES</b>						
94. The following are not within children's reach: small objects, toys, and toy parts that have a diameter less than 1¼ inch and a length between 1 inch and 2¼ inches; balls and toys with spherical, egg shaped, or elliptical parts that are smaller than 1¾ inches in diameter; toys with sharp points and edges; plastic bags; Styrofoam® objects; coins; rubber or latex balloons; safety pins; marbles; magnets; foam blocks, books, or objects; latex gloves; bulletin board tacks or glitter. ( <a href="#">Std. 6.4.1.2</a> )	1	2	3	4		
<b>NOTES</b>						
95. Securely installed, guards (for example, gates) are at the top and bottom of each open stairway where infants and toddlers are in care. ( <a href="#">Std. 5.1.5.4</a> )	1	2	3	4	NA	
<b>NOTES</b>						
96. Children over 12 months of age who can feed themselves are actively supervised by a caregiver/teacher. The caregiver/teacher is within arm's reach of the child's high chair or feeding table or is seated at the same table. ( <a href="#">Std. 4.5.0.6</a> )	1	2	3	4	NA	
<b>NOTES</b>						
97. Foods that are choking hazards are not served to toddlers. Food for toddlers is served in pieces ½ inches or smaller. ( <a href="#">Std. 4.5.0.10</a> )	1	2	3	4	NA	
<b>NOTES</b>						

Infants and/or Toddlers — Injury Prevention — *Continued*

	Never	Sometimes	Usually	Always	Not Applicable	No Opportunity
List and rate other federal, state, local and/or accreditation standards/regulations that may apply:						
	1	2	3	4		N Op
<b>NOTES</b>						

**INFANTS ONLY: Activity, Sleep, Safety, Nutrition**

Are there infants under 12 months of age in this program?

Yes:        If yes, complete items below No:        If no, you have completed the Checklist.

Infants Only — Activity, Sleep, Safety

98. Sunscreen is not applied to infants 6 months of age or younger. Infants less than 6 months of age are not in direct sunlight. ( <a href="#">Std. 3.4.5.1</a> )	1	2	3	4	NA	N Op
<b>NOTES</b>						
99. Infants have supervised tummy time while awake at least once each day. ( <a href="#">Std. 3.1.3.1</a> )	1	2	3	4		N Op
<b>NOTES</b>						
100. Infants are not seated more than 15 minutes at a time except during meals. ( <a href="#">Std. 3.1.3.1</a> )	1	2	3	4		
<b>NOTES</b>						
101. All infants are placed to sleep on their backs, in a crib, on a firm mattress, with a tightly fitting sheet. Only one infant is placed in each crib. ( <a href="#">Std. 3.1.4.1</a> )	1	2	3	4		N Op
<b>NOTES</b>						
102. Soft or loose bedding and other objects are kept away from sleeping infants and are not in safe sleep environments (for example, not in cribs). This includes bumpers, pillows, positioners, blankets, quilts, bibs, diapers, flat sheets, sheepskins, toys and stuffed animals. One-piece blanket sleepers may be used for warmth. ( <a href="#">Std. 3.1.4.1</a> )	1	2	3	4		
<b>NOTES</b>						
103. The room temperature where infants sleep is comfortable for a lightly clothed adult. ( <a href="#">Std. 3.1.4.1</a> )	1			4		
<b>NOTES</b>						
104. Infants who fall asleep any place that is not a crib are moved and placed to sleep on their backs in a crib. Examples of places where infants may not be left to sleep are car seats, high chairs, swings, infant seats, beanbag chairs, and futons. ( <a href="#">Std. 3.1.4.1</a> )	1			4		N Op
<b>NOTES</b>						
105. *Cribs meet the current guidelines approved by CPSC and ASTM International standards. Crib slats are spaced no more than 2 3/8 inches apart. The crib has a firm mattress that is fitted so that no more than two fingers can fit between the mattress and the crib side in the lowest position. Cribs with drop sides are not used. Cribs are placed away from window blinds or draperies. ( <a href="#">Std. 5.4.5.2</a> )	1	2	3	4	NA	
<b>NOTES</b>						
106. Infants mobile enough to potentially climb out of a crib sleep on cots or mats. ( <a href="#">Std. 5.4.5.2</a> )	1	2	3	4	NA	N Op
<b>NOTES</b>						

## Infants Only — Nutrition

	Never	Sometimes	Usually	Always	Not Applicable	No Opportunity
107. Bottles or containers with mother's milk are labeled with the infant's full name, date and time the milk was expressed. Mother's milk is stored in the refrigerator or freezer. ( <a href="#">Std. 4.3.1.3</a> )	1	2	3	4	NA	
<b>NOTES</b>						
108. Bottles of formula prepared from powder or concentrate or ready-to-feed formula are labeled with the child's full name and the time and date of preparation. ( <a href="#">Std. 4.3.1.5</a> )	1	2	3	4	NA	
<b>NOTES</b>						
109. If caregivers/teachers warm bottles and infant foods, bottles are warmed under running warm tap water or by placing in a container of water no warmer than 120°F. Bottles and infant foods are not thawed or warmed in microwave ovens. The temperature of warmed milk does not exceed 98.6 F. ( <a href="#">Stds. 4.3.1.3, 4.3.1.9</a> )	1	2	3	4		
<b>NOTES</b>						
110. Infants are not fed solid foods sooner than 4 months (preferably 6 months). Introductory foods are single ingredient. ( <a href="#">Std. 4.3.1.11</a> )	1			4	NA	N Op
<b>NOTES</b>						
111. Infants who are learning to feed themselves are actively supervised by a caregiver/teacher. Infants are seated within arm's reach of caregiver/teacher at all times while being fed or eating. ( <a href="#">Std. 4.5.0.6</a> )	1	2	3	4		N Op
<b>NOTES</b>						
112. Foods that are choking hazards are not served to infants. Food for infants is served in pieces ¼ inch or smaller. ( <a href="#">Std. 4.5.0.10</a> )	1			4		N Op
<b>NOTES</b>						
List and rate other federal, state, local and/or accreditation standards/regulations that may apply:						
	1	2	3	4		N Op
<b>NOTES</b>						

## Incident Report Form

Fill in all blanks and boxes that apply.

Name of Program: \_\_\_\_\_ Date of Incident: \_\_/\_\_/\_\_

Address of program: \_\_\_\_\_

Child's Name: \_\_\_\_\_ Sex: M F Birthdate: \_\_/\_\_/\_\_

Time of Incident: \_\_\_\_\_ am/pm Witnesses: \_\_\_\_\_

Details of Incident:

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Location where incident occurred:

Playground     Classroom     Bathroom     Hallway

Kitchen     Doorway     Large muscle room or gym

Unknown     Other (specify) \_\_\_\_\_

Injury received, or severe illness that occurred: \_\_\_\_\_

Type of injury or illness: \_\_\_\_\_

First aid or care provided by: \_\_\_\_\_

Further treatment provided by: \_\_\_\_\_

EMS (911) or other medical professional notified?  If so, time notified: \_\_\_\_\_ am/pm

Parent of guardian notified?  If so, time notified: \_\_\_\_\_ am/pm

Number of days of limited activity from this incident: \_\_\_\_\_ Follow-up plan for care for the child:

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Signature of staff member: \_\_\_\_\_ Date: \_\_\_\_\_



## Let's Move! Child Care Checklist Quiz

The *Let's Move!* Child Care best practices are listed on the left. Please check the box under the statement that best describes your current situation.

Best Practices	Yes, fully meeting this best practice	Making progress on meeting this best practice	Ready to get started on meeting this best practice	Unable to work on meeting this best practice right now
<b>Answer if you serve TODDLERS or PRESCHOOLERS</b>				
Drinking water is visible and available inside and outside for self-serve	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
100% fruit juice is limited to no more than 4-6 oz. per day per child and parents are encouraged to support this limit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sugary drinks, including fruit drinks, sports drinks, sweet tea, and soda, are never offered	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Children 2 years and older are served only 1% or skim/non-fat milk (unless otherwise directed by the child's health provider)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fruit (not juice) and/or a vegetable is served to toddlers and preschoolers at every meal  (French fries, tator tots, and hash browns don't count as vegetables)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
French fries, tator tots, hash browns, potato chips, or other fried or pre-fried potatoes are offered to toddlers and preschoolers no more than once a month  (Baked fries are okay)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chicken nuggets, fish sticks, and other fried or pre-fried forms of frozen and breaded meats or fish are offered to toddlers and preschoolers no more than once a month	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Answer if you serve PRESCHOOLERS</b>				
All meals to preschoolers are served family style so that children are encouraged to serve themselves with limited help	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Best Practices	Yes, fully meeting this best practice	Making progress on meeting this best practice	Ready to get started on meeting this best practice	Unable to work on meeting this best practice right now
<b>Answer if you serve PRESCHOOLERS</b>				
Preschoolers, including children with special needs, are provided with 120 minutes or more of active play time every day, both indoor and outdoor  (for half-day programs, 60 minutes or more is provided for active play every day)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
We strive to limit total screen time (e.g., TV and DVD viewing, computer use) to no more than 30 minutes for preschoolers at child care per week or never, and we work with parents/caregivers to ensure that children have no more than 1-2 hours per day  (for half-day programs, we strive to limit total screen time to no more than 15 minutes per week or never)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Parents of preschoolers are provided screen time reduction and/or media literacy education such as special programs, newsletters, or information sheets, 2 or more times per year	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Answer if you serve TODDLERS</b>				
Toddlers, including children with special needs, are provided with 60-90 minutes or more of active play time every day, both indoor and outdoor (for half-day programs, 30 minutes or more is provided for active play every day)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Answer if you serve INFANTS or TODDLERS</b>				
Screen time for toddlers and infants is limited to no more than 3-4 times per year or is never allowed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Answer if you serve INFANTS</b>				
Breastfeeding mothers are provided access to a private room for breastfeeding or pumping, other than a bathroom, with appropriate seating and privacy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Short supervised periods of tummy time are provided for all infants, including those with special needs several times each day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

# Medication Administration Packet

Authorization to Give Medicine  
PAGE 1—TO BE COMPLETED BY PARENT

## CHILD'S INFORMATION

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Name of Facility/School Today's Date

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Name of Child (First and Last) Date of Birth

Name of Medicine \_\_\_\_\_

Reason medicine is needed during school hours \_\_\_\_\_

Dose \_\_\_\_\_ Route \_\_\_\_\_

Time to give medicine \_\_\_\_\_

Additional instructions \_\_\_\_\_

Date to start medicine \_\_\_\_/\_\_\_\_/\_\_\_\_ Stop date \_\_\_\_/\_\_\_\_/\_\_\_\_

Known side effects of medicine \_\_\_\_\_

Plan of management of side effects \_\_\_\_\_

Child allergies \_\_\_\_\_

## PRESCRIBER'S INFORMATION

\_\_\_\_\_  
Prescribing Health Professional's Name

\_\_\_\_\_  
Phone Number

## PERMISSION TO GIVE MEDICINE

I hereby give permission for the facility/school to administer medicine as prescribed above. **I also give permission for the caregiver/teacher to contact the prescribing health professional about the administration of this medicine. I have administered at least one dose of medicine to my child without adverse effects.**

\_\_\_\_\_  
Parent or Guardian Name (Print)

\_\_\_\_\_  
Parent or Guardian Signature

\_\_\_\_\_  
Address

\_\_\_\_\_  
Home Phone Number

\_\_\_\_\_  
Work Phone Number

\_\_\_\_\_  
Cell Phone Number

Adapted with permission from the NC Division of Child Development to the Department of Maternal and Child Health at the University of North Carolina at Chapel Hill, Connecticut Department of Public Health, and Healthy Child Care Pennsylvania.

# Receiving Medication

PAGE 2—TO BE COMPLETED BY CAREGIVER/TEACHER

Name of child \_\_\_\_\_

Name of medicine \_\_\_\_\_

Date medicine was received \_\_\_\_/\_\_\_\_/\_\_\_\_

## Safety Check

- 1. Child-resistant container.
  - 2. Original prescription or manufacturer's label with the name and strength of the medicine.
  - 3. Name of child on container is correct (first and last names).
  - 4. Current date on prescription/expiration label covers period when medicine is to be given.
  - 5. Name and phone number of licensed health care professional who ordered medicine is on container or on file.
  - 6. Copy of Child Health Record is on file.
  - 7. Instructions are clear for dose, route, and time to give medicine.
  - 8. Instructions are clear for storage (eg, temperature) and medicine has been safely stored.
  - 9. Child has had a previous trial dose.
- Y  N  10. Is this a controlled substance? If yes, special storage and log may be needed.

\_\_\_\_\_  
Caregiver/Teacher Name (Print)

\_\_\_\_\_  
Caregiver/Teacher Signature

# Medication Log

**PAGE 3—TO BE COMPLETED BY CAREGIVER/TEACHER**

Name of child \_\_\_\_\_ Weight of child \_\_\_\_\_

	Monday	Tuesday	Wednesday	Thursday	Friday
Medicine					
Date	/ /	/ /	/ /	/ /	/ /
Actual time given	AM _____	AM _____	AM _____	AM _____	AM _____
	PM _____	PM _____	PM _____	PM _____	PM _____
Dosage/amount					
Route					
Staff signature					

	Monday	Tuesday	Wednesday	Thursday	Friday
Medicine					
Date	/ /	/ /	/ /	/ /	/ /
Actual time given	AM _____	AM _____	AM _____	AM _____	AM _____
	PM _____	PM _____	PM _____	PM _____	PM _____
Dosage/amount					
Route					
Staff signature					

*Describe error/problem in detail in a Medical Incident Form. Observations can be noted here.*

Date/time	Error/problem/reaction to medication	Action taken	Name of parent/guardian notified and time/date	Caregiver/teacher signature

<b>RETURNED</b> to parent/guardian	Date	Parent/guardian signature	Caregiver/teacher signature
	/ /		
<b>DISPOSED</b> of medicine	Date	Caregiver/teacher signature	Witness signature
	/ /		

The recommendations in this publication do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate. Copyright © 2013 American Academy of Pediatrics. All Rights Reserved. The American Academy of Pediatrics does not review or endorse any modifications made to this document and in no event shall the AAP be liable for such changes.

# Medication Incident Report

Date of report \_\_\_\_\_ School/center \_\_\_\_\_

Name of person completing this report \_\_\_\_\_

Signature of person completing this report \_\_\_\_\_

Child's name \_\_\_\_\_

Date of birth \_\_\_\_\_ Classroom/grade \_\_\_\_\_

Date incident occurred \_\_\_\_\_ Time noted \_\_\_\_\_

Person administering medication \_\_\_\_\_

Prescribing health care provider \_\_\_\_\_

Name of medication \_\_\_\_\_

Dose \_\_\_\_\_ Scheduled time \_\_\_\_\_

Describe the incident and how it occurred (wrong child, medication, dose, time, or route?)

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Action taken/intervention \_\_\_\_\_

Parent/guardian notified? Yes \_\_\_\_\_ No \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

Name of the parent/guardian that was notified \_\_\_\_\_

Follow-up and outcome \_\_\_\_\_

Administrator's signature \_\_\_\_\_

Adapted with permission from Healthy Child Care Colorado.

## Permission to Apply Sunscreen to Child

(Name of Child) \_\_\_\_\_

As the parent of the above child, I recognize that too much sunlight may cause sunburn and increase my child's risk of getting skin cancer someday. Therefore, I give my permission for personnel at: (Child Care Program name) \_\_\_\_\_ to apply sunscreen of SPF-30 or higher to my child before going outdoors.

I understand the sunscreen may be applied to exposed skin, including but not limited to the face, tops of the ears, nose and bare shoulders, arms, and legs.

I have checked applicable information regarding the type and use of sunscreen for my child:

\_\_\_ I do not know of any allergies my child has to sunscreen.

\_\_\_ Staff may use the sunscreen of their choice following the directions or recommendations printed on the bottle.

\_\_\_ My child is allergic to some sunscreens. Please use only the following brand(s) and type(s) of sunscreen:

\_\_\_ For medical or other reasons, please do not apply sunscreen to the following areas of my child's body:

Parent's full name (print): \_\_\_\_\_

Parent's signature: \_\_\_\_\_

Date: \_\_\_\_\_

## Permission to Apply Sunscreen to Child

(Name of Child) \_\_\_\_\_

As the parent of the above child, I recognize that too much sunlight may cause sunburn and increase my child's risk of getting skin cancer someday. Therefore, I give my permission for personnel at: (Child Care Program name) \_\_\_\_\_ to apply sunscreen of SPF-30 or higher to my child before going outdoors.

I understand the sunscreen may be applied to exposed skin, including but not limited to the face, tops of the ears, nose and bare shoulders, arms, and legs.

I have checked applicable information regarding the type and use of sunscreen for my child:

I do not know of any allergies my child has to sunscreen.

Staff may use the sunscreen of their choice following the directions or recommendations printed on the bottle.

My child is allergic to some sunscreens. Please use only the following brand(s) and type(s) of sunscreen:

For medical or other reasons, please do not apply sunscreen to the following areas of my child's body:

Parent's full name (print): \_\_\_\_\_

Parent's signature: \_\_\_\_\_

Date: \_\_\_\_\_



## Permission to Photograph

I, \_\_\_\_\_, give permission for \_\_\_\_\_ to  
(Parent or Guardian name) (Child Care Provider)  
 photograph my child, \_\_\_\_\_, for the following purposes:  
(Child's name)

Type of Use:	(Please check one)	
	Grant Permission	Decline Permission
<b>Still Photographs:</b>		
Display in my personal scrapbook	<input type="checkbox"/>	<input type="checkbox"/>
Give photographs possibly containing your child to current clients	<input type="checkbox"/>	<input type="checkbox"/>
Display in facility's scrapbook or bulletin boards, shown to current and prospective clients	<input type="checkbox"/>	<input type="checkbox"/>
Display still photos on child care website*	<input type="checkbox"/>	<input type="checkbox"/>
Post photos on child care's Facebook page	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>
<b>Videos:</b>		
Give video to current parents	<input type="checkbox"/>	<input type="checkbox"/>
YouTube™ promotional video	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>
<b>Other (please list):</b>		
	<input type="checkbox"/>	<input type="checkbox"/>

\*Only first names and possibly last initials (in the event of two or more children with the same first name) will be displayed on the facility website.

I understand that it is my responsibility to update this form in the event that I no longer wish to authorize one or more of the above uses. I agree that this form will remain in effect during the term of my child's enrollment.

Signed:

\_\_\_\_\_

(Parent or Guardian signature)

\_\_\_\_\_

(Date)



## Permission to Transport

I give permission for (name of program) \_\_\_\_\_

to transport (name of child) \_\_\_\_\_

for the purpose of \_\_\_\_\_

on the following dates \_\_\_\_\_

Parent name (Print): \_\_\_\_\_

Parent signature: \_\_\_\_\_

Date: \_\_\_\_\_

## Permission to Transport

I give permission for (name of program) \_\_\_\_\_

to transport (name of child) \_\_\_\_\_

for the purpose of \_\_\_\_\_

on the following dates \_\_\_\_\_

Parent name (Print): \_\_\_\_\_

Parent signature: \_\_\_\_\_

Date: \_\_\_\_\_



# Safe Sleep Policy for Infants in Child Care Programs

All childcare providers at \_\_\_\_\_ [program name] will follow safe sleep recommendations for infants to reduce the risk of Sudden Infant Death Syndrome (SIDS), Sudden Unexpected Infant Death (SUID), and the spread of contagious diseases:

1. Infants will always be put to sleep on their backs.
2. Infants will be placed on a firm mattress, with a fitted crib sheet, in a crib that meets the Consumer Product Safety Commission safety standards.
3. No toys, soft objects, stuffed animals, pillows, bumper pads, blankets, positioning devices or extra bedding will be in the crib or draped over the side of the crib.
4. Sleeping areas will be ventilated and at a temperature that is comfortable for a lightly clothed adult. Infants will not be dressed in more than one extra layer than an adult.
5. If additional warmth is needed, a one-piece blanket sleeper or sleep sack may be used.
6. The infant's head will remain uncovered for sleep. Bibs and hoods will be removed.
7. Sleeping infants will be actively observed by sight and sound.
8. Infants will not be allowed to sleep on a couch, chair cushion, bed, pillow, or in a car seat, swing or bouncy chair. If an infant falls asleep anyplace other than a crib, the infant will be moved to a crib right away.
9. An infant who arrives asleep in a car seat will be moved to a crib.
10. Infants will not share cribs, and cribs will be spaced 3 feet apart.
11. Infants may be offered a pacifier for sleep, if provided by the parent.
12. Pacifiers will not be attached by a string to the infant's clothing and will not be reinserted if they fall out after the infant is asleep.
13. When able to roll back and forth from back to front, the infant will be put to sleep on his back and allowed to assume a preferred sleep position.
14. In the rare case of a medical condition requiring a sleep position other than on the back, the parent must provide a signed waiver from the infant's physician.
15. Our child care program is a smoke-free environment.
16. Our child care program supports breastfeeding.
17. Awake infants will have supervised "Tummy Time".



Courtesy of the Back to Sleep Campaign, NICHD, NIH, DHHS

\*This policy reflects the safe sleep research as of November, 2011.

## Resources

Caring for Our Children, National Health and Safety Performance Standards, 3rd Edition.

<http://nrckids.org/CFOC3/index.html>

SIDS and Other Sleep Related Infant Deaths: Expansion of Recommendations for a Safe Infant Sleeping Environment, Pediatrics, AAP Policy. <http://pediatrics.aappublications.org/content/128/5/e1341.full>

CCHP Tummy Time. [http://www.ucsfchildcarehealth.org/pdfs/healthandsafety/tummy\\_time\\_0209.pdf](http://www.ucsfchildcarehealth.org/pdfs/healthandsafety/tummy_time_0209.pdf)

Safe Sleep for Infants in Child Care Programs: Reducing the Risk of SIDS and SUID Health and Safety Note. [http://www.ucsfchildcarehealth.org/pdfs/healthandsafety/SIDS\\_EN\\_1111.pdf](http://www.ucsfchildcarehealth.org/pdfs/healthandsafety/SIDS_EN_1111.pdf)



# SEIZURE ACTIVITY LOG

NOTE: This should be accompanied by a *Seizure Care Plan* established and on-file for this child.

Name of Child: \_\_\_\_\_

Room: \_\_\_\_\_

DATE	TIME	CIRCUMSTANCES PRECEDING <small>(activity participating in)</small>	DESCRIBE SEIZURE*	LENGTH OF SEIZURE	ACTIONS TAKEN BY STAFF	CHILD'S BEHAVIOR AFTER SEIZURE	STAFF INITIALS

**\*What To Look For and Note Above:**

- How did the seizure start? Did the seizure start in just one part of the body and then spread, or did it involve the whole body from the beginning?*
- Was there smacking or licking of the lips? Eyelid fluttering? Picking or fumbling movements of the hands?*
- Was the child able to respond to any outside stimulus (for example, name called, gently shaking shoulder)? Was the response normal/confused/no response?*
- Were there stiff and/or jerking movements?*
- Was the jaw clenched or the tongue bitten?*
- Was there any color change or breathing problem?*
- How long did the actual seizure last?*

# Seizure Care Plan

The seizure care plan defines all members of the team, communication guidelines (how, when, and how often), and all information necessary to support a child who may experience seizures while in child care.

Name of Child: \_\_\_\_\_ Date: \_\_\_\_\_

Facility Name: \_\_\_\_\_

.....  
**Description of seizure condition/disorder:** \_\_\_\_\_

**Describe what the child's seizures look like:** (1) what part of the body is affected? (2) How long do the seizure episodes usually last?

**Describe any known "triggers"** (behaviors and/or symptoms) **for seizure activity:** \_\_\_\_\_

**Detail the frequency and duration of child's typical seizure activity:** \_\_\_\_\_

Has the child been treated in the emergency room due to their seizures? \_\_\_\_\_ How many times? \_\_\_\_\_

Has the child stayed overnight in the hospital due to their seizures? \_\_\_\_\_ How many times? \_\_\_\_\_

**Team Member Names and Titles** (parents of the child are to be included)

Care Coordinator (responsible for developing and administering the Seizure Care Plan): \_\_\_\_\_

*① If training is necessary, then ALL team members will be trained.*

**Planned strategies to support the child's needs and safety issues when the child has a seizure:**

(e.g., diapering/toileting, outdoor play, nap/sleeping, etc) \_\_\_\_\_

- Individualized Family Service Plan (IFSP) attached.     Individualized Education Plan (IEP) attached.

PROBLEM	TREATMENT	EXPECTED RESPONSE
At risk for injury due to uncontrolled seizure activity.	If a seizure occurs, staff will remove objects from the area and place a folded towel/clothing beneath the child's head. Protective helmet is worn as prescribed.	Injuries related to seizure activity will be prevented.
At risk for aspiration of respiratory secretions or vomitus during seizure activity.	If a seizure occurs, staff will roll the child onto his/her side.	Child will not aspirate during seizure activity.
Self-esteem disturbance related to occurrence of seizure or use of protective helmet.	Provide many opportunities for success. Praise achievements and accomplishments. Provide opportunities for child to express feelings about seizures and any activity restrictions. Reassure the other children in the group that the child will be OK if a seizure occurs.	The child will successfully adapt to requirements of living with a seizure disorder. The child will demonstrate a positive attitude toward learning activities. Other children will feel safe.
Parent and child may not be aware of possible triggers.	Staff will document the occurrence of any seizure activity on attached <i>Seizure Activity Log</i> .	Parents, staff and the child will learn to identify triggers and how to avoid them.
Child may be very sleepy, but not unresponsive after a seizure occurs.	Staff will make sure that the child is responsive after a seizure, then will allow the child to sleep/rest after the seizure.	The child may safely sleep/rest, if needed, after seizure occurs.

**Communication**

What is the team's communication goal and how will it be achieved (e.g., notes, communication log, phone calls, meetings, etc.): \_\_\_\_\_

How often will team communication occur:     Daily     Weekly     Monthly     Bi-monthly

Date and time specifics: \_\_\_\_\_

**Other Professionals Involved**

**Telephone**

Health Care Provider (MD, NP, etc.): \_\_\_\_\_

Occupational Therapist: \_\_\_\_\_

Physical Therapist: \_\_\_\_\_

Neurology Specialist: \_\_\_\_\_

Other: \_\_\_\_\_

**Specific Medical Information**

❖ Medical documentation provided & attached:  Yes  No

**Information Exchange Form** completed by Health Care Provider on-file.

Any known allergies to food and/or medications: \_\_\_\_\_

❖ Medication to be administered:  Yes  No

**Medication Administration Form** completed by Health Care Provider and parents is on file (including: type of medications, method, amount, time schedule, potential side effects, etc.)

**Special Staff Training Needs**

Type (be specific): \_\_\_\_\_

Training done by: \_\_\_\_\_ Date of Training: \_\_\_\_\_

**Additional Information** (include any unusual episodes/behavior changes that might arise while in care and how the situation should be handled)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Support Program the Child is Involved With Outside of Child Care**

Name of program: \_\_\_\_\_

Address and telephone: \_\_\_\_\_

Contact person: \_\_\_\_\_

**Emergency Procedures**

*Special emergency and/or medical procedure required.* Emergency instructions: \_\_\_\_\_

❖ Call 911 if:  Seizure lasts longer than \_\_\_\_ minutes.  Child is unresponsive after seizure.

Other: \_\_\_\_\_

Emergency contact: \_\_\_\_\_ Telephone: \_\_\_\_\_

**Follow-up: Updates/Revisions**

This *Seizure Care Plan* will be updated/revised whenever medications or child's health status changes, or at least every 12 months as a result of the collective input from team members.

Date for revision and team meeting: \_\_\_\_\_

## Special Health Care Plan

The special health care plan defines all members of the care team, communication guidelines (how, when, and how often), and all information on appropriately accommodating the special health concerns and needs of this child while in child care.

**Name of Child:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Facility Name:** \_\_\_\_\_

.....  
**Description of condition(s):** (include description of difficulties associated with each condition) \_\_\_\_\_

.....  
**Team Member Names and Titles** (parents of the child are to be included)

Care Coordinator (responsible for developing and administering the Special Health Care Plan): \_\_\_\_\_

① If training is necessary, then all team members will be trained.

Individualized Family Service Plan (IFSP) attached       Individualized Education Plan (IEP) attached

**Outside Professionals Involved**

**Telephone**

Health Care Provider (MD, NP, etc.): \_\_\_\_\_

\_\_\_\_\_

Speech & Language Therapist: \_\_\_\_\_

\_\_\_\_\_

Occupational Therapist: \_\_\_\_\_

\_\_\_\_\_

Physical Therapist: \_\_\_\_\_

\_\_\_\_\_

Psychologist/Mental Health Consultant: \_\_\_\_\_

\_\_\_\_\_

Social Worker: \_\_\_\_\_

\_\_\_\_\_

Family-Child Advocate: \_\_\_\_\_

\_\_\_\_\_

Other: \_\_\_\_\_

\_\_\_\_\_

**Communication**

How the team will communicate (notes, communication log, phone calls, meetings, etc.):

\_\_\_\_\_

How often will team communication occur:     Daily     Weekly     Monthly     Bi-monthly     Other \_\_\_\_\_

Date and time specifics: \_\_\_\_\_

**Specific Medical Information**

❖ Medical documentation provided and attached:  Yes  No

**Information Exchange Form** completed by health care provider is in child,s file on site.

❖ Medication to be administered:  Yes  No

**Medication Administration Form** completed by health care provider and parents are in child's file on site (including: type of medications, method, amount, time schedule, potential side effects, etc.)

Any known allergies to foods and/or medications: \_\_\_\_\_

Specific health-related needs: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Planned strategies to support the child's needs and any safety issues while in child care: (diapering/toileting, outdoor play, circle time, nap/sleeping, etc.) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Plan for absences of personnel trained and responsible for health-related procedure(s): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Other (i.e., transportation, field trips, etc.): \_\_\_\_\_

\_\_\_\_\_

**Special Staff Training Needs**

Training monitored by: \_\_\_\_\_

1) Type (be specific): \_\_\_\_\_

Training done by: \_\_\_\_\_ Date of Training: \_\_\_\_\_

2) Type (be specific): \_\_\_\_\_

Training done by: \_\_\_\_\_ Date of Training: \_\_\_\_\_

3) Type (be specific): \_\_\_\_\_

Training done by: \_\_\_\_\_ Date of Training: \_\_\_\_\_

**Equipment/Positioning**

❖ Physical Therapist (PT) and/or Occupational Therapist (OT) consult provided:  Yes  No  Not Needed

Special equipment needed/to be used: \_\_\_\_\_

\_\_\_\_\_

Positioning requirements (attach additional documentation as necessary): \_\_\_\_\_

\_\_\_\_\_

Equipment care/maintenance notes: \_\_\_\_\_

**Nutrition and Feeding Needs**

**Nutrition and Feeding Care Plan Form** completed by team is in child's file on-site . See for detailed requirements/needs.

**Behavior Changes** (be specific when listing changes in behavior that arise as a result of the health-related condition/concerns)

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**Additional Information** (include any unusual episodes that might arise while in care and how the situation should be handled)

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**Support Programs the Child Is Involved with Outside of Child Care**

1. Name of program: \_\_\_\_\_ Contact person: \_\_\_\_\_  
Address and telephone: \_\_\_\_\_  
Frequency of attendance: \_\_\_\_\_
  
2. Name of program: \_\_\_\_\_ Contact person: \_\_\_\_\_  
Address and telephone: \_\_\_\_\_  
Frequency of attendance: \_\_\_\_\_
  
3. Name of program: \_\_\_\_\_ Contact person: \_\_\_\_\_  
Address and telephone: \_\_\_\_\_  
Frequency of attendance: \_\_\_\_\_

**Emergency Procedures**

Special emergency and/or medical procedure required (additional documentation attached)

Emergency instructions: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Emergency contact: \_\_\_\_\_ Telephone: \_\_\_\_\_

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**Follow-up: Updates/Revisions**

This Special Health Care Plan is to be updated/revised whenever child's health status changes or at least every \_\_\_\_\_ months as a result of the collective input from team members.

Due date for revision and team meeting: \_\_\_\_\_

## Symptom Record

Child's Name \_\_\_\_\_ Date \_\_\_\_\_

### Symptoms:

Circle or write in other symptoms:

runny nose    sore throat    cough    vomiting    diarrhea    wheezing

trouble breathing    stiff neck    rash    trouble urinating    pain

itching    trouble sleeping    earache    headache    stomachache

### Other Symptoms:

\_\_\_\_\_  
\_\_\_\_\_

When did symptoms begin? \_\_\_\_\_

How long are the symptoms lasting? \_\_\_\_\_

How severe and how often are the symptoms? \_\_\_\_\_  
\_\_\_\_\_

**Changes in the child's behavior:** \_\_\_\_\_  
\_\_\_\_\_

Child's temperature: \_\_\_\_\_ Time taken: \_\_\_\_\_

Circle method used:    armpit    oral    ear canal

Type and quantity of food and fluid the child ingested in the past 12 hours: \_\_\_\_\_  
\_\_\_\_\_

Frequency of urine and bowel movement, in the past 12 hours? Any abnormalities?  
\_\_\_\_\_  
\_\_\_\_\_

Exposure to medications, animals, insects, soaps, new foods:  
\_\_\_\_\_  
\_\_\_\_\_

Exposure to other people with similar symptoms:    Yes    No    Unsure

If yes, type of illness or symptoms: \_\_\_\_\_

Child's other conditions that might affect this illness (for example: asthma or diabetes)

---

---

Should child be excluded from child care?    YES                      NO

If yes, when can child return to care? \_\_\_\_\_

Action taken and/or treatment given:

---

---

Time of action or treatment: \_\_\_\_\_

Name of person taking action or providing treatment: \_\_\_\_\_

Name and title of person completing this form: \_\_\_\_\_

Adapted from Model Child Care Health Policies, PA Chapter-American Academy of Pediatrics. 4<sup>th</sup> Ed.

**References, Index  
and Good Health Handbook Survey  
(Revision 2015)**





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## Good Health Handbook Survey (Revision 2015)

A committee to revise the Good Health Handbook was formed that included representatives from the Oklahoma State Department of Health Maternal and Child Health Service, Child Guidance Service, and Acute Disease Service, as well as the Oklahoma Department of Human Services Child Care Services.

This resource is intended to be user-friendly and relevant to anyone caring for children. We would appreciate your input on these revisions and hope that you will take the time to fill out this survey.

Feel free to provide written comments along with the corresponding page number of the area you are addressing. Suggestions for future revisions are welcome. All surveys will be reviewed and future revisions will be made based on feedback and the latest research. No identifying information will be used. Thank you for your assistance. Please contact Peggy Byerly, Child and Adolescent Health, Early Childhood Coordinator, [peggycb@health.ok.gov](mailto:peggycb@health.ok.gov) for questions about this survey.

1. **What is your job title?** \_\_\_\_\_

2. **What type of program do you work in?**

- |   |  |                                     |
|---|--|-------------------------------------|
| <input type="checkbox"/> Child Care Center      | <input type="checkbox"/> Child Care Home | <input type="checkbox"/> School     |
| <input type="checkbox"/> Pre-Kindergarten       | <input type="checkbox"/> Kindergarten    | <input type="checkbox"/> Head Start |
| <input type="checkbox"/> Other (describe) _____ |  |                                     |

3. **Is the new information in the revised Good Health Handbook helpful to you as you care for or work with children?**

NO       SOMEWHAT       YES

If so, please **list the specific topics** or page numbers that have been helpful and why.

4. **Have you gained new knowledge that has helped in caring for children through your use of the Good Health Handbook?**

NO       SOMEWHAT       YES

Comments:

**5. Have you utilized the Good Health Handbook to provide information to parents?**

NO  YES

**If yes, what type of information have you shared with parents?**

**6. Have you utilized the Good Health Handbook to help you access additional resources for children's health, safety, and development?**

NO  YES

Comments:

**7. Please rate the revised 2015 Good Health Handbook in the following areas:**

Ease of finding information needed: \_\_\_\_ Difficult \_\_\_\_ Average \_\_\_\_ Good \_\_\_\_ Excellent

Ease of understanding information: \_\_\_\_ Difficult \_\_\_\_ Average \_\_\_\_ Good \_\_\_\_ Excellent

**8. What additional information or resources would be helpful to include?**

**9. Please provide any additional comments in the space below**

- a. Chapter or Topic
- b. Page Number
- c. Specific Comment:

(Feel free to attach additional pages if needed)

Please email this form to: Child and Adolescent Health, Early Childhood Coordinator, [peggycb@health.ok.gov](mailto:peggycb@health.ok.gov), or submit online. Here is the link for the survey: <https://www.surveymonkey.com/r/GoodHHB>.



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